Schneider
Medicaid

State of Rhode Island and Providence Plantations

DEPARTMENT OF HUMAN SERVICES

Office of the Director

68 pp.

February 11, 2008

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives
Congress of the United States
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Subject: January 16, 2008 Request for Information/Documents

Dear Chairman Waxman:

We appreciate the opportunity to provide the House Committee on Oversight and Government Reform (the Committee) with materials to support the Committee's investigation of the Administration's regulatory actions on Medicaid. As requested, we are providing you with an analysis of the impact of each of the proposed or final rules. Each analysis was prepared specifically to support your request. Where we were able within our very limited resources due to severe budgetary and time constraints, we have also provided certain documents relevant to the subject areas of the proposed or final rules. Unfortunately, the State lacks the administrative and legal resources to provide you with materials that follow the instructions provided with your request (e.g., Bates-stamped numbering). Nonetheless, we have attempted to label enclosures clearly so as to relate them to our responses herein. We apologize for any inconvenience this might cause the Committee.

1. Cost Limits on Public Providers

CMS 2258-FC, a *Final Rule* with comment period published in the *Federal Register* on June 29, 2007, clarifies that entities involved in the financing of the non-Federal share of Medicaid payments must be a unit of government; clarifies the documentation required to support a Medicaid certified public expenditure (CPE); limits Medicaid reimbursement for health care providers that are operated by units of government to an amount that does not exceed the health care provider's cost of providing services to Medicaid individuals; requires all health care providers to receive and retain the full amount of total computable payments for services furnished under the approved Medicaid State Plan; and makes conforming changes to provisions governing the State Children's Health Insurance

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Program (SCHIP) to make the same requirements applicable, with the exception of the cost limit on reimbursement. This *Final Rule* was effective July 30, 2007. The State of Rhode Island certified public expenditures are for school-based administration furnished by Local Education Agencies (LEAs). As outlined in item #6 of this correspondence, the State of Rhode Island will lose all FFP for school-based administration after February 26, 2008. To quantify the impact of this on the State, in SFY 2007 the State claimed a total of $3,844,344, 50 percent of which or $1,922,172 was Federal.

2. Payment for Graduate Medical Education

CMS 2279-P, a *Proposed Rule* published in the *Federal Register* on May 23, 2007, would clarify that costs and payments associated with Graduate Medical Education (GME) programs are not expenditures for Medical Assistance that are Federally reimbursable under the Medicaid program.

If adopted in its proposed form, this *Proposed Rule* would have no impact on the State of Rhode Island. GME expenditures are funded by the Rhode Island General Assembly through a legislative grant process. In State Fiscal Year[1] (SFY) 2007, GME payments to grantees totaled $425,000 based on hospital 2005 Medicare cost reports.

3. Payment for Hospital Outpatient Services

CMS 2213-P, a *Proposed Rule* published in the *Federal Register* on September 28, 2007, would amend the regulatory definition of outpatient hospital services for the Medicaid program by aligning the Medicaid definition more closely with the Medicare definition particularly directed upper payment limits (UPL).

If adopted in its proposed form, this *Proposed Rule* would have no impact on the State of Rhode Island. Rhode Island's Medicaid reimbursement system for hospitals is a cost-based system based upon the ration of cost to charges (RCC), except for laboratory and imaging services. As such, payments are under the Medicare UPL. The Rhode Island General Assembly directed Medicaid to pay hospitals the difference between the RCC and the UPL for outpatient hospital services. (Enclosure A) Rhode Island has submitted a State Plan Amendment and is awaiting approval from CMS.

4. Provider Taxes

CMS 2275-P, a *Proposed Rule* published in the *Federal Register* on March 23, 2007, would, among other things, revise the threshold under the indirect guarantee hold harmless arrangement test to reflect the provisions of the Tax Relief and Health Care Act of 2006, by providing that, when determining whether there is an indirect guarantee

[1] The State Fiscal Year ends June 30th.

under the 2-prong test for any part of a fiscal year on or after January 1, 2008 through September 30, 2011, the allowable amount that can be collected from a health care-related tax is reduced from 6 to 5.5 percent of net patient revenues received by the taxpayers.

If adopted in its proposed form, this *Proposed Rule* would have impact on the State of Rhode Island as the tax rate on providers (i.e., nursing homes and ICF-MRs) in SFY 2007 was 6 percent. This would result in an annual impact of approximately $330,000. The other provisions of the *Proposed Rule* would also have no impact on the State.

5. Coverage of Rehabilitation Services

CMS 2261-P, a *Proposed Rule* published in the *Federal Register* on August 13, 2007, would amend the definition of Medicaid rehabilitative services in order to, according to CMS, provide for beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records. CMS also asserted that the *Proposed Rule* would ensure the fiscal integrity of claimed Medicaid expenditures by clarifying the service definition and providing that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. These services and programs include, but are not limited to, foster care, child welfare, education, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and any other non- Medicaid services from Federal, State, or local programs.

The *Proposed Rule* poses many problems for the State of Rhode Island outlined in our correspondence to CMS (Enclosure B and C), as well as other States. First, the *Proposed Rule* ignores the historical precedence forged between the States and the Federal Government in providing Federal financial participation (FFP) for rehabilitation services. Each Medicaid State Plan is unique and dynamic, as State Medicaid programs have evolved to meet the health care needs of its low-income residents over the past nearly 40 years. A change in a Medicaid State Plan is accomplished through a State Plan Amendment (SPA), which is proposed by a State and either approved or denied by CMS.[2] Forty-six States, including Rhode Island, include within their rehabilitation services component of the Medicaid State Plan mental health "rehabilitation/stabilization"[3] and Rhode Island and 32 other States have "other" rehabilitation services elements included in their approved Medicaid State Plans – many going back more than 30 years.

States have relied on these Federal approvals to develop and implement a variety of delivery systems for many different Medicaid-eligible populations. Now, with the

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[2] It should be noted, however, that CMS has been increasingly delaying or withholding SPA approvals.
[3] Centers for Medicare & Medicaid Services. *Medicaid At-a-Glance, 2005.*

issuance of this *Proposed Rule*, CMS places into jeopardy those very delivery systems and threatens the Federal/State partnership that has been the hallmark of this program since Medicaid was established in 1967.

Second, the proposed regulatory language begs the question of the departure point for amendment on the legal basis for rehabilitation services. Section 1905(a)(13) of the Act provides:

> "(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, **for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level**; " (emphasis added)

CMS has relied upon the emphasized statutory language as the essence of its approach to benefit reduction. This ignores that this section of the Act was intentionally written by Congress to provide great latitude to the States in the formulation of their Medicaid State Plans, recognizing the deference accorded the States in Section 1901 of the Act of "enabling each State, as far as practicable under the conditions in such State."

Third, the nomenclature in the *Proposed Rule* is a one size-fits-all approach and fails to recognize State differences as well as "practice" differences. For example, Rhode Island's approved rehabilitation services section of its Medicaid State Plan includes, among other things, Early Intervention (EI) and behavioral health services. By Federal law, EI requires that an Individual Family Service Plan (IFSP) be developed, upon which all interventions are based. In the behavioral health field, the development of "treatment" plans upon which interventions are based has been the standard forever. The one-size-fits-all approach imbedded in the *Proposed Rule* would require the use of "rehabilitation" plan, necessitating duplication (e.g., an IFSP as well as a rehabilitation plan) if incorporated into final rulemaking. States must have flexibility in this regard, so as not to waste precious resources in duplicative efforts.

Fourth, the proposed language in 42 CFR 440.130(d)(1)(i)(A) requiring both "reduction" **and** "restoration" would seem to ignore child beneficiaries, in particular, where a legitimate rehabilitation goal may be overcoming developmental delays, for example. The regulations must recognize specifically in the instance of children that the goal for a child may be something yet to be realized by the child. This is something so critical that it needs to be addressed throughout the regulations particularly where particular services are defined or used.

Fifth, on page 45204 of the *Federal Register*, CMS states with respect to a "written rehabilitation Plan":

> "We recognize, however, that rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services."

The "maintaining functioning" in order to prevent more costly acute services (e.g., inpatient hospital services) was so important to the State of Rhode Island that in 1996 the State incorporated the following into its contracts with managed care organizations (MCOs) the definition of "medically necessary services": "services necessary to prevent a decremental change in either medical or mental health status" (Enclosure D).

Finally, State compliance would pose an immense administrative burden. Among other things, the State would need to change State law, a SPA would need to be prepared, waiver amendments would need to be prepared, State policy would need to be changed, systems would need to be changed, managed care contracts would need to be amended, workers would need to be trained, providers would need to be notified and would need to spend an enormous amount of time just developing and updating rehabilitation plans let alone trying to provide rehabilitation services, and most importantly, beneficiaries and their families, caretakers, and advocates would need to be informed for all affected services. The "Impact" section of the *Proposed Rule* makes no reference to such costs on the States other than to state:

> "Thus, we are unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local government agencies or geographic regions under Executive Order 12866. We invite public comment on the potential impact of the rule."

If adopted in its proposed form, this *Proposed Rule* would have an immense impact on the State of Rhode Island. The State has attempted to quantify the impact as follows based upon SFY 2006 expenditures, trended forward to SFY 2007 by eight percent:

- **Rehabilitation services provided to children** – loss of 60 percent of the amount claimed for child beneficiaries, or $115,243,449

- **Inpatient hospital and other institutional services provided to other populations** – increase of 10 percent of the total amount claimed for child beneficiaries, or $2,596,466

- **Rehabilitation services provided to other populations to maintain functioning** – loss of 15 percent of the total amount claimed for other populations, or $10,508,732

- **Inpatient hospital and other institutional services provided to other populations** – increase of 10 percent of the total amount claimed for other populations, or $2,915,453

- **Administrative burden on the State** – estimated at $1.5 to $2.0 million for changes and a minimum of $250,000 annually for oversight and monitoring

6. Payments for Costs of School Administration and Transportation Services

CMS 2287-P, a *Proposed Rule* published in the *Federal Register* on September 7, 2007, would eliminate Federal financial participation (FFP) for school-based administration. On December 28, 2007, a *Final Rule* was published in the *Federal Register* virtually unchanged from the *Proposed Rule.* This means that FFP will no longer be available for school-based administration as of February 26, 2007.

The *Final Rule* is a complete reversal of ten years of Federal policy, as the following brief chronology shows:

- **August 1997** – The Health Care Financing Administration (HCFA) issued *Medicaid and School Health: A Technical Assistance Guide.* The document stated: "Title XIX of the Act provides for the availability of FFP for state's claims for administrative expenditures that are found to be necessary by the Secretary for the proper and efficient administration of the Medicaid state plan." The guide delineated "Guiding Principles of Administrative Claiming".

- **May 21, 1999** – HCFA issued a *State Medicaid Director Letter* (SMDL) addressing three school-based claiming issues: (1) use of a bundled rate to pay for medical services provided to Medicaid-eligible children; (2) State claiming for school health-related transportation services for children with Individualized Education Plans (IEPs); and (3) State claiming for school health-related administrative activities. With respect to the latter, HCFA indicated that a "guide is expected to be published this Summer".

- **February 2000** – HCFA issued a draft *Medicaid School-Based Administrative Claiming Guide* inviting comments.

- **November 2002** – The Centers for Medicare & Medicaid Services (CMS) issued a revised draft *Medicaid School-Based Administrative Claiming Guide* inviting comments.

- **May 28, 2003** – A cover memorandum from CMS was sent distributing the *Medicaid School-Based Administrative Claiming Guide.*

Interestingly, the preamble to the *Proposed Rule* only acknowledged the 1997 Technical Assistance Guide and the 2003 Claiming Guide. The preamble failed to acknowledge the collaboration between what has historically been a Federal-State partnership that led to the final Claiming Guide. The *Proposed Rule* belied that historical partnership and the agreements between the States and Federal Government to claim FFP for school-based administrative costs under Title XIX. More interestingly, the preamble to the *Final Rule* failed to acknowledge any history whatsoever between the Federal Government and States in this regard including the issuance of the documents referenced above.

Subsequent to publication of the Technical Assistance Guide, the State of Rhode Island submitted a Cost Allocation Plan (CAP) to HCFA seeking approval to claim FFP for school-based administration. By letter dated May 18, 2000, HCFA approved in writing the State's CAP for Cost Center 189 for Title XIX Medicaid Administrative Costs for Local Education Agencies, effective January 1, 2000 (Enclosure E). Subsequent to publication of the 2003 Claiming Guide, the State of Rhode Island developed and distributed the *Rhode Island Medicaid School Based Administrative Claiming Guide* in August 2004. In developing its guide to school-based administrative claiming, the State sought to follow the 2003 Claiming Guide assiduously including submitting a draft of the guide to CMS for review. The final guide (Enclosure F), which reflected CMS' comments on the draft, was transmitted to CMS with the following explanation:

> "Because the Centers for Medicare & Medicaid Services (CMS) has issued new guidance for claiming administrative costs under Cost Center 189, the Department has revised its claiming manual to reflect this guidance. The purpose of this correspondence is to formally transmit these materials to the Department of Health and Human Services (DHHS)."

With publication of the *Final Rule*, CMS obviated an existing "approved plan" between the State and CMS pertaining to school-based administrative claiming under Medicaid as noted above. We believe that Section 1903(a) of the Act precludes this:

> "SEC. 1903. *[42 U.S.C. 1396b]* (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—"

Nonetheless, the State of Rhode Island will lose all FFP for school-based administration after February 26, 2008. To quantify the impact of this on the State, in SFY 2007 the State claimed a total of $3,844,344, 50 percent of which or $1,922,172 was Federal.

7. Targeted Case Management

CMS 2237-IFC, an *Interim Final Rule* with comment period published in the *Federal Register* on December 4, 2007, revises current Medicaid regulations to incorporate changes made by the Deficit Reduction Act of 2005. In addition, it incorporates provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Omnibus Budget Reconciliation Act of 1986, the Tax Reform Act of 1986, the Omnibus Budget Reconciliation Act of 1987, and the Technical and Miscellaneous Revenue Act of 1988, concerning case management and targeted case management services. This *Interim Final Rule* provides for optional coverage of case management services or targeted case management services furnished under the Social Security Act. This *Interim Final Rule* clarifies the situations in which Medicaid will pay for case management activities and also clarifies when payment will not be consistent with proper and efficient operation of the Medicaid program, and is not available. The effective date of this *Interim Final Rule* is March 3, 2008.

Like rehabilitation services, the Rhode Island Medicaid State Plan has included targeted case management (TCM) for as many as 12 discrete Medicaid-eligible populations based upon age, disability, illness or condition, or other identifiable or combination of characteristics, dating back as far as 1991. TCM is provided Statewide and there has always been comparability of services per Section 1902(a)(10)(B) of the Act. Theoretically, the State could take advantage of the new flexibility afforded by Section 1915(g)(2)(B) of the Act for a State to furnish TCM without regard to State-wideness or comparability. However, as a geographically small State this would not make much sense, nor would it fit philosophically with how the State has provided Medicaid-covered services in general. Therefore, the State anticipates no savings due to these provisions.

The freedom of choice provisions for case management providers in 42 CFR 431.51 will have an impact on the discrete TCM-covered populations other than individuals with development disabilities or with chronic mental illness, the only populations exempted from freedom of choice provisions. Because the State had limited TCM provider participation for other populations to assure the TCM providers have the necessary knowledge, skills and experience to address the services needs of these populations (e.g., individuals with HIV/AIDS), the State knows that freedom of choice will have some impact. After 15 or more years of experience limiting provider participation, the State just cannot quantify the impact of freedom of choice.

The State does not necessarily anticipate any impact of the third-party liability (TPL) provisions in Section 1915(g)(4) of the Act. The State does not believe that commercial

insurance, for example, will cover TCM. It is not so clear, however, regarding "reimbursement under a medical, social, educational, or other program." On page 68079 of the *Federal Register*, CMS states: "FFP is only available for the cost of case management or targeted case management services if there are no there third parties liable to pay for those services. . ." Is another program liable if it has no funding available? Time will tell. CMS has provided no clues whatsoever as to how estimated savings were derived for this provision (or any other covered by the *Interim Final Rule*), so the State cannot at this point in time estimate the impact of this provision

In FFY 2007, the State claimed $10,639,891 for TCM, of which $5,569,983 was Federal. The State estimates that because of the amended definition of TCM under the *Interim Final Rule*, the State could have lost up to 25 percent of the FFY 2007 amount, or $2,659,973 ($1,392,996 Federal) had the *Interim Final Rule* have been in effect during FFY 2007. The State estimates that one-third of this would have been due to CMS' misconstruing the case management services that are "an integral part of the managed care services" and the remainder (two-thirds) would have been due to other reasons.

We would hope that the information and enclosures contained herein will be of use to the Committee. If you have any questions concerning these materials, please contact John Young, the State's Medicaid Director, at (401) 462- 3575 or JYoung@dhs.ri.gov. Thank you.

Sincerely,

Gary D. Alexander
Director

Enclosures

ENCLOSURE A

ARTICLE 13 SUBSTITUTE A AS AMENDED

RELATING TO HOSPITAL PAYMENTS

SECTION 1. Effective July 1, 2007, the department of human services is hereby authorized and directed to amend its regulations and the Rhode Island State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act for reimbursement to hospitals for outpatient services as follows:

Hospitals – Outpatient adjustment payments. – (a) Each hospital in the state of Rhode Island, as defined in section 23-17-38.1(b)(1), shall receive a quarterly adjustment payment during state fiscal year 2008 of an amount determined as follows:

(1) Determine the percent of the state's total Medicaid outpatient and emergency department services (exclusive of physician services) provided by each hospital during the hospital's fiscal year ending during 2006;

(2) Determine the sum of all Medicaid payments to hospitals made for outpatient and emergency department services (exclusive of physician services) provided during each hospital's fiscal year ending during 2006 not including any recoupments or settlements;

(3) Multiply the sum of all Medicaid payments as determined in (2) by 30.2 percent and then multiply that result by each hospital's percentage of the state's total Medicaid outpatient and emergency department services as determined in (1) to obtain the total outpatient adjustment for each hospital to be paid in SFY 2008;

(4) Pay each hospital on or about July 20, 2007, October 20, 2007, January 20, 2008, and April 20, 2008 one-quarter of its total outpatient adjustment as determined in (3) above.

(b) The amounts determined in subsection (a) are in addition to Medicaid outpatient payments and emergency services payments (exclusive of physician services) paid to hospitals in accordance with current state regulation and the Rhode Island Plan for Medicaid Assistance pursuant to Title XIX of the Social Security Act and are not subject to recoupment or settlement.

(c) The payments are expressly conditioned upon approval by the secretary of the United States Department of Health and Human Services, or his or her authorized representative, of any Medicaid state plan amendment necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2008 for such payments, such amendment to be filed not later than July 9, 2007.

SECTION 2. Section 40-8-13.2 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-13.2. Prospective rate methodology for in-state hospital services. – As a condition of participation in the established prospective rate methodology for reimbursement of in-state hospital services, every hospital shall submit year-end settlement reports to the department within ~~two (2)~~ one years from the close of a hospital's fiscal year. In the event that a participating hospital fails to timely submit a year-end settlement report as required, the department shall withhold financial cycle payments due by any state agency with respect to this hospital by not more than ten percent (10%) until the report is received.

SECTION 3. This article shall take effect upon passage.

ENCLOSURE B

Mailed Comments Must Be Received by October 12, 2007. If Mailed, One Original and Two Copies Need to Be Submitted. Comments May Also Be Submitted Electronically to: http://www.cms.hhs.gov/eRulemaking
Comments Must Be Received by 5:00 p.m. EST on the Date Specified.

October 11, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

The Rhode Island Executive Office of Health and Human Services is pleased to submit these comments on the *Proposed Rule* published in the *Federal Register* on August 13, 2007 that would make fundamental changes in the definition of Medicaid rehabilitative services and, therefore, the availability of Federal financial participation (FFP) for such services.

Our response and the specific comments and issues are presented for each section of the *Proposed Rule* for File Code CMS-2261-P, as suggested in the *Federal Register*.

GENERAL COMMENTS

There are some overarching issues with the *Proposed Rule*. First, Medicaid is a Federal/State partnership. As the Centers for Medicare & Medicaid Services (CMS) has noted[1]:

> "The Medicaid Program provides medical benefits to groups of low-income people, some who may have no medical insurance or inadequate medical insurance. Although the Federal government establishes general guidelines for the program, **the Medicaid program requirements are actually established by each State.**" (emphasis added)

These "actual" program requirements are accomplished through the establishment of a Medicaid State Plan for each State, subject to approval of CMS. CMS and its predecessor organizations (e.g., Health Care Financing Administration, or HCFA) that have administered Title XIX of the Social Security Act (Act) have approved State Plans for Medicaid programs for all States including rehabilitation service components for Rhode Island and all other States.

[1] Centers for Medicare & Medicaid Services. *Medicaid At-a-Glance, 2005*, 2.

Each Medicaid State Plan is unique and dynamic, as State Medicaid programs have evolved to meet the health care needs of its low-income residents over the past nearly 40 years. A change in a Medicaid State Plan is accomplished through a State Plan Amendment (SPA), which is proposed by a State and either approved or denied by CMS.[2] Forty-six States, including Rhode Island, include within their rehabilitation services component of the Medicaid State Plan mental health "rehabilitation/stabilization"[3] and Rhode Island and 32 other States have "other" rehabilitation services elements included in their **approved** Medicaid State Plans.

States have relied on these Federal approvals to develop and implement a variety of delivery systems for many different Medicaid-eligible populations. Now, with the issuance of this *Proposed Rule*, CMS places into jeopardy those very delivery systems.

Second, the *Proposed Rule* ignores the position of rehabilitation services set forth by Congress. The very first section of Title XIX of the Act provides:

> "SEC. 1901. *[42 U.S.C. 1396]* For the purpose of **enabling each State, as far as practicable under the conditions in such State**, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) **rehabilitation** and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance." (emphasis added)

Not only does Section 1901 stipulate in the very first sentence of Title XIX of the Act that States establish the program, but "rehabilitation" is the only service specified even though it is an "optional" service.

CMS seeks an unprecedented narrowing of rehabilitation services eligible for FFP, as the summary of the *Proposed Rule*[4] states:

> "This proposed rule **would amend the definition** of Medicaid rehabilitative services in order to provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records. The proposed rule would also ensure the fiscal integrity of claimed Medicaid expenditures by clarifying the service definition and providing that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. These services and programs include, but are not limited to, foster care, child welfare,

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[2] It should be noted, however, that CMS has been increasingly delaying or withholding SPA approvals.
[3] Centers for Medicare & Medicaid Services. *Op.Cit.*,
[4] *Federal Register*, 72(155), August 13, 2007, 45201.

education, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and any other non- Medicaid services from Federal, State, or local programs." (emphasis added)

The proposed language begs the question of the departure point for amendment on the legal basis for rehabilitation services. Section 1905(a)(13) of the Act provides:

> "(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, **for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;** " (emphasis added)

CMS has relied upon the emphasized statutory language as the essence of its approach to benefit reduction. This ignores that this section of the Act was intentionally written by Congress to provide great latitude to the States in the formulation of their Medicaid State Plans, recognizing the deference accorded the States in Section 1901 of the Act of "enabling each State, as far as practicable under the conditions in such State." We believe that the current Federal regulations at 42 CFR 440.130(d) embrace the intent of the statute.

Third, important clarification of the extent of CMS' definitional change for rehabilitation services is not in the regulation itself, but in the preamble to the regulation. We believe that the absence of these clarifications from the body of the regulation raises significant issues, examples of which follow:

- On page 45204 of the *Federal Register*, CMS states with respect to a "written rehabilitation Plan":

  > "We recognize, however, that rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services.

  This recognition of "maintaining functioning" appears nowhere in the regulation itself.

- On page 45206 of the *Federal Register*, CMS states with respect to "habilitation" services:

  > "We intend to provide for a delayed compliance date so that States will have a lesser of 2 years or 1 year after the close of the first regular session

of the State legislature that begins after this regulation becomes final before we will take enforcement action."

If this *Proposed Rule* were made effective as written, we would need substantial lead time in order to implement the provisions and not just for those pertaining to habilitation. State law would need to be changed, State policy would need to be changed, systems would need to be changed, workers would need to be trained, providers would need to be notified, and most importantly, beneficiaries and their families, caretakers, and advocates would need to be informed for **all** affected services.

- The preamble makes numerous references to other parts of the regulations including, for example:
    - 42 CFR 440.110 – Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders
    - 42 CFR 440.160 – Inpatient psychiatric services for individuals under age 21
    - 42 CFR 440.230 – Sufficiency of amount, duration, and scope
    - 42 CFR 440.240 – Comparability of services for groups
    - 42 CFR 441 Subpart D – Inpatient psychiatric services for individuals under age 21 in psychiatric facilities and programs
    - 42 CFR 441 Subpart I – Community Supported Living Arrangements Services

  Yet, there are few references to these other sections in the proposed regulation itself.

The problem with having material being in the preamble as opposed to the actual regulations lies with the financial review process. It is our experience that those conducting financial reviews, be it CMS, the Office of the Inspector General, the General Accounting Office, or State auditors, rely on the exact language of the regulations.

PROVISIONS OF THE *PROPOSED RULE*

Our comments on individual sections of the regulatory changes in the *Proposed Rule* follow.

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services

- *Section 440.130(d)(1)(i) Recommended by a physician or other licensed practitioner of the healing arts* – The language in this section of the *Proposed Rule* raises several issues. First, in Rhode Island, and in some other States, "certification" as opposed to "licensure" is used for some practitioners of the healing arts. Certification plays exactly the same role as licensure in establishing standards that the practitioner must meet and in defining the practitioner's scope of practice. The regulations should recognize these nuances in State law. Second, the language in subsection (A) requiring both "reduction" **and** "restoration" would seem to ignore child beneficiaries, in particular, where a legitimate rehabilitation goal may be overcoming developmental delays, for example. The regulations must recognize specifically in the instance of children that the goal for a child may be something yet to be realized by the child. This is something so critical that it needs to be addressed throughout the regulations particularly where particular services are defined or used. Third, the "maintaining functioning" discussed above must be embraced in the regulation. In 1996, in its contracts with managed care organizations (MCOs) Rhode Island included within the definition of "medically necessary services" the following: "services necessary to prevent a decremental change in either medical or mental health status", to assure compliance with Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. Because of statutory comparability requirements, this definition was applied to all Medicaid-eligible populations in Rhode Island. Prevention of decremental change is a legitimate and important goal for rehabilitative services and must, therefore, be incorporated into any acceptable regulatory language. This is a critical issue that needs to be addressed throughout the regulations.

- *Section 440.130(d)(1)(iv) Under the direction of* – Besides the licensure/certification issue above, we find the last sentence in this subsection inadequate in assuring that States may legitimately cover other supervisory arrangements for rehabilitation services other than the "therapies" listed in this section of the *Proposed Rule*. We would suggest in this regard that a State's option to include other supervisory arrangements be stated positively, rather than the "is not meant to exclude" language proposed.

- *Section 440.130(d)(3) Written rehabilitation plan* – The detailed requirements proposed are excessive and would place a voluminous administrative burden on practitioners. Practitioners could conceivably spend weeks if not months devising a plan for a given beneficiary rather than actually providing rehabilitation services. The actual requirements far and away exceed the definition proposed in Section 440.130(1)(v). An equally important issue is that subsection 440.130(d)(3)(vi) only addresses "medical and remedial services" and ignore those other rehabilitation services defined in subsections 440.130(d)(1)(v) and 440.130(d)(2).

- *Section 440.130(d)(2) Scope of services* – It is unclear what is meant by "not otherwise covered under the plan." Is "plan" referring to rehabilitation plan or the Medicaid State Plan to take into account EPSDT, or is it intended to mean

something else? Also, while we appreciate seeing such other services as assistive devices delineated, we believe more flexibility needs to be accorded the States. For example, we presently cover assistive technology "services", not just devices.

- *Section 441.45(b)(1)* – CMS proposes to limit the availability of FFP for services "furnished through a non-medical program as either a benefit or administrative activity including services that are **intrinsic elements** of programs other than Medicaid, such as foster care, child welfare, child care, vocational and prevocational training, housing, parole and probation, juvenile justice and public guardianship." (emphasis added) The *Proposed Rule* does not define "intrinsic elements" but, rather, provides examples of things that "would not be paid under Medicaid." Not only would this provide CMS with unilateral discretion to deny FFP, but it ignores the fact that Rhode Island and other States have worked assiduously and collaboratively to develop and implement systems of care for Medicaid-eligible individuals who are engaged with other programs. Much of this development was specifically done with the encouragement of and at the behest of other parts of the U.S. Department of Health and Human Services as part of such initiatives a CSP, CASPP, child welfare reform, etc. Some were even undertaken at the behest of CMS. Consider, for example, the following[5]:

> "Federal agencies have certain responsibilities to enforce the nation's laws prohibiting discrimination on the basis of disability. Equally important, however, is our additional role of partnering with States to achieve the goals of the laws. We have therefore committed ourselves to examining federal policies, practices and procedures that may present obstacles to fulfillment of the goals of section 504 of the 1973 Rehabilitation Act, the Americans with Disabilities Act (ADA), and the U.S. Supreme Court's decision in Olmstead v. L.C. We are also committed to providing active assistance to States in their conscientious efforts to build better health and long term service systems that enable integrated, community living."

ADDITIONAL COMMENTS

If the *Proposed Rule* were promulgated as either an *Interim Final Rule* or *Final Rule*, State compliance would pose an immense administrative burden on the States. Significant changes would be required including State law, State policy, MMIS programming as well as workers would need to be trained, providers would need to be notified, and most importantly, beneficiaries and their families, caretakers, and advocates would need to be informed for **all** affected services. The "Impact" section of the *Proposed Rule* makes no reference to such costs on the States other than to state:

> "Thus, we are unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local

[5] Centers for Medicare & Medicaid Services. *SMDL #01-007*, January 10, 2001.

government agencies or geographic regions under Executive Order 12866. We invite public comment on the potential impact of the rule."

Since CMS asked for comment, let us put an estimate succinctly – every Federal dollar CMS proposes to save will represent a dollar for dollar direct cost to the States.
Not included in the administrative burden described above is that we, and every other State wishing to continue covering rehabilitative services, will need to prepare and submit a SPA or new waiver. Our recent experience with CMS is that CMS is not well equipped to handle the existing volume of SPA and waiver requests, let alone ones that would derive from this effort by CMS. Our recent experience is also that there are substantial delays in Federal approval. For a State like Rhode Island, which is a "Medicaid expansion State" for State Children's Health Insurance Program (SCHIP) purposes, an SCHIP SPA would also be required. In addition, our experience is that CMS would likely require "waiver" amendments for existing waivers.

Thank you for consideration of our comments.

Sincerely,

ENCLOSURE C

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Mental Health, Retardation, and Hospitals
Office of the Director
14 Harrington Road
Barry Hall
Cranston, Rhode Island 02920-0380
(401) 462-3201; Fax (401) 462-3204

October 12, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Reference: File Code CMS-2261-P

To Whom It May Concern:

The Rhode Island Department of Mental Health, Retardation, and Hospitals submits the following comments on the Proposed Rule: *Medicaid Program; Coverage for Rehabilitative Services.*

COMMENTS ON SPECIFIC ITEMS IN PROPOSED RULE

§440.130(d)(1)(v) *Rehabilitation Plan*

This section requires that the Rehabilitation Plan is "developed by a qualified provider(s)…with input from the individual, the individual's family, the individual's authorized decision maker and/or of the individual's choosing in the development, review and modification of the goals and services."

Comments:
We agree that active participation in the development of the plan as well as in all required reviews and modifications is important. However, along the lines of client-centered planning and the client's right to determine their own goals, we suggest that the term "family" be preceded by the phrase "…, if clinically appropriate," to allow for situations in which family participation is not in the client's best interests. This change should carry throughout the entire document.

We believe a grammatical revision is needed to this sentence to reflect the preamble language. It should read:
"The plan is developed by a qualified provider(s)…with input from the individual, the

individual's family, the individual's authorized decision maker and/or persons of the individual's choosing in the development, review and modification of the goals and services." This change should be made in the next sentence as well.

This section requires that the plan have a timeline that includes reevaluation at a period of no longer than one year.

Comment:
We believe that a timeline of "one year" is excessive and recommend review at least every 6-months.

§440.130(d)(1)(vi) *Restorative Services*
Comment:
This definition contains wording stating that "restorative services" are those that enable an individual to perform a function but also state that the individual does not have to have actually performed the function in the past. This section should be modified to reference the needs of children with serious emotional disturbances and provide a specific exemption in their case rather than leaving the issue up to reviewer discretion.

Of even more concern is the thought that services designed to help a client maintain their current level of functioning are only allowable when they are necessary to help an individual achieve a rehabilitation goal. Given the cyclical nature of mental illness, we recommend this section be modified to allow services that are required to preserve a client's level of functioning and prevent them from deteriorating to the point that more intensive, and often more costly, services are required.

We recommend inclusion of language that reflects the concept that some recreational activities or vocational services can be regarded as rehabilitative if the primary purpose is to reduce disability and restore a person to a previous functioning level.

§440.130(d)(3) *Written Rehabilitation Plan*
Comments:
We are concerned that this requirement has the potential to add to the administrative time and expense of providers, thereby further stressing a system that is already stretched thin.

For example, this section at least implies that the rehabilitation plan is to live as a separate document. In the behavioral health field, it is more common for individuals to have an overall treatment plan addressing all aspects of their care. While this does not appear to be specifically prohibited, we suggest that this section allow for a consolidated plan.

With regard to client participation, the requirement that the individual must participate in planning and sign the final document needs to be modified to allow for situations in which the individual cannot, or will not, actually participate/sign. In this case, agency clinical records documenting their attempts to engage the client, even if they are unsuccessful, should be considered adequate.

In cases in which the provider does participate/sign, it is also important that the plan contain evidence of the extent of their participation, preferably in the form of case notes documenting ongoing involvement as opposed to a simple signature.

§441.45(a)(2) *Rehabilitative Services*
Comment:
This section should be modified to state that rehabilitative services can be provided with the intent to maintain a client at their highest functional level under certain circumstances.

§441.45(b)(2) *Rehabilitative Services*
Comment:
This section refers to "habilitation services." We recommend that a clearer definition of "Habilitation services" be included. Also, the parenthetical statement should be deleted and a revised statement should be included that states that persons with developmental disabilities who need rehabilitative services as described in §441.45(a) should be able to access them.

PAYMENT FOR SERVICES

While it does not appear to be a specific requirement of this regulation, CMS recently began requiring States to implement approaches that move away from daily or case rates towards a system of paying for 15-minute increments of service. This approach is detrimental to the provision of the some of the primary, evidence-based mental health services that are increasingly being offered as a unified set of interventions. The primary example of this is Assertive Community Treatment (ACT) which was recognized as an EBP in the Surgeon General's Report.

What is especially concerning is that while one Federal agency under the HHS umbrella, SAMHSA-Center for Mental Health Services, is moving at top speed to promote the ACT model which is most effectively funded as a single, integrated service, a sister agency (CMS) is showing all signs of pulling the model apart through unrealistic payment requirements.

We urge CMS to work with other federal agencies and states to devise and implement payment methodologies that best support evidence based practice.

Thank you for the opportunity to comment,

Ellen R. Nelson, Ph.D.
Director

ENCLOSURE D

GENERAL PROVISIONS

This Agreement, including the attachments hereto, is made and entered into effective the 1st day of January, 2005, between the Rhode Island Department of Human Services (the "Department") and Neighborhood Health Plan of Rhode Island (the "Contractor"). ("Agreement") This Agreement is entered into in conformity with Department procedures.

ARTICLE I: DEFINITIONS

As used in this Agreement, each of the following terms shall have the indicated meaning unless the context clearly requires otherwise:

1.01 CAPITATION PAYMENT

Capitation Payment means a payment the Department makes periodically to Contractor on behalf of each Member enrolled under a contract for the provision of medical services under the State plan. The Department makes the payment regardless of whether the particular Member receives services during the period covered by the payment.

1.02 CENTER FOR CHILD AND FAMILY HEALTH

Center for Child and Family Health (CCFH) is operated by the Rhode Island Department of Human Services ("DHS"). The DHS Director has appointed a CCFH Administrator. The CCFH shall administer this contract, shall issue any notices regarding the failure to meet performance requirements and shall assess any damages.

1.03 CMS

CMS means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

1.04 COMPREHENSIVE RISK CONTRACT

Comprehensive Risk Contract means a risk contract that covers comprehensive services, that is, inpatient hospital services and the other services in Attachment A hereto.

1.05 CONTRACTOR

Contractor means the Health Plan that has executed this formal agreement with the State to enroll and serve RIte Care members under the conditions specified in this Agreement.

1.06 CONTRACT SERVICES

Contract Services mean the services to be delivered by the Contractor, which are so designated in Article II of this Agreement.

1.07 COVERED SERVICES

Covered Services mean the medical and behavioral healthcare service and benefits packages described in Article II of this Agreement set forth in Attachments A through F to this Agreement.

1.08 DAYS

Days mean calendar days unless otherwise specified.

1.09 DEPARTMENT

Department shall mean the Rhode Island Department of Human Services.

1.10 EPSDT

EPSDT means Early Periodic Screening, Diagnosis and Treatment, a comprehensive set of services provided to all eligible children under age 21.

1.11 EMERGENCY DENTAL CONDITION

Emergency Dental Condition means a dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, eliminate acute infection, pulpal death, or loss of teeth.

1.12 EMERGENCY SERVICES

Emergency Services means covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title and (2) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.13 FAMILY

Family means the adult head of household, his or her spouse and all minors in the household for whom the adult has parent or guardian status.

1.14 HEALTH CARE PROFESSIONAL

Health Care Professional means a physician or any of the following: a podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy assistant).

1.15 HEALTH INSURANCE PORTABLILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance and Portability and Accountability Act of 1996, or HIPAA, that protects health insurance coverage of workers and their families when they change or lose their jobs. HIPAA also requires the Secretary of the U.S. Department of Health and Human Services to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers.

1.16 HEALTH PLAN, PLAN, OR HMO

Health Plan, Plan, or HMO means any organization that is licensed as a health maintenance organization ("HMO") by the Rhode Island Department of Business Regulation, or otherwise meets the requirements of Section 2.02 of this Agreement, and contracts with the State to provide services pursuant to Title XIX of the Social Security Act to RIte Care members.

1.17 HOME CARE SERVICES

Home Care Services means those services provided under a home care plan authorized by a physician including full-time, part-time, or intermittent care by a licensed nurse or home health aide (certified nursing assistant) for patient care and including, as authorized by a physician, physical therapy, occupational therapy, respiratory therapy, and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living area, such as

bedroom and bathroom, and doing the client's laundry and shopping. Homemaking services are only covered when the RIte Care member also needs personal care services. Home care services do not include respite care, relief care, or day care.

1.18 IBNR (Incurred But Not Reported)

IBNR means liability for services rendered for which claims have not been received.

1.19 MEDICAL NECESSITY, MEDICALLY NECESSARY, OR MEDICALLY NECESSARY SERVICE

The term "medical necessity", "medically necessary", or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

1.20 MEMBER OR RITE CARE MEMBER

Member or RIte Care Member as the term is used herein, means an eligible person who is enrolled with a Contractor.

1.21 MID-LEVEL PRACTITIONERS

Mid-level Practitioners include physician assistants, certified nurse practitioners, and certified nurse midwives. These individuals are subject to the laws and regulations of Rhode Island and may not exceed the authority of these regulations.

1.22 NON-PARTICIPATING PHYSICIAN

Non-participating Physician means a physician licensed to practice who has not contracted with or is not employed by the Contractor to provide services under this Agreement.

1.23 PARTY

Party means either the State of Rhode Island or the Contractor in its capacity as a contracting party to this Agreement.

1.24 PLAN PHYSICIAN OR PARTICIPATING PHYSICIAN

Plan physician or participating physician means a physician licensed to practice in Rhode Island who has contracted with or is employed by the Contractor to furnish services covered in this Agreement.

1.25 POST-STABILIZATION CARE SERVICES

Post-stabilization care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 422.113(c).

1.26 PREPAID BENEFIT PACKAGE

Prepaid Benefit Package means the set of health care-related services for which Health Plans will be responsible to provide and for which the Health Plan will receive reimbursement through a per member per month pre-determined capitation rate.

1.27 PRIMARY CARE

Primary care means all health care services and laboratory services customarily furnished by or through a general practitioner, family practitioner, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

1.28 PRIMARY CARE PROVIDER (PCP)

Primary Care Provider means the individual Plan Physician or team selected by, or assigned to the member to provide and coordinate all of the member's health care needs and to initiate and monitor referrals for specialized services when required. Primary Care Providers shall be Medical Doctors and Doctors of Osteopathy in the following specialties: family and general practice, pediatrics, obstetrics and gynecology, and internal medicine. Primary Care Providers also shall meet the credentialing criteria established by the plan and approved by the State. The Primary Care Provider may designate other participating plan clinicians who can provide or authorize a member's care. As provided for in Section 2.08.02.05, mid-level practitioners may function as Primary Care Providers under certain circumstances.

1.29 PRIVATE DUTY NURSING

Private Duty Nursing means those skilled nursing services authorized by a physician when the physical or mental condition of the patient requires more skilled nursing than intermittent visiting nursing care and takes into account family strengths and other family obligations.

1.30 RELATED GROUPS

Related Groups mean those groups described in Section 2.04.02.01 though 2.04.02.03 for which the Contractor must make coverage available, although they are outside of the actual RIte Care program, and in Section 2.04.02.04, for which the Contractor may make the coverage available.

1.31 RISK CONTRACT

Risk contract means a contract under which the Contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

1.32 RITE CARE

RIte Care is the health care delivery program, through which the State of Rhode Island serves the Family independence Program ("FIP") and FIP-related portions of its Title XIX (Medicaid) population, uninsured pregnant women and children under age nineteen living in households that meet specified eligibility criteria, and other specific eligible populations as designated by the State.

1.33 RITE CARE ELIGIBLES

RIte Care Eligibles mean those Title XIX eligible groups described in Sections 2.04.01.01 through 2.04.01.04.

1.34 RITE SHARE

Rite Share is the premium assistance program created and operated under Chapter 40-8.4-12 et seq. of the Rhode Island General Laws and the amended state plan under Title XIX (Medicaid) for the State of Rhode Island pursuant to which the State of Rhode Island shall purchase employer-sponsored health insurance for RIte Care Eligible low-income working individuals and their families who are eligible for employer-sponsored insurance but could not otherwise afford such insurance.

1.35 RITE SHARE MEMBER

RIte Share member means a Medical Assistance eligible person who is enrolled in an employer-sponsored benefit plan.

1.36 SIBLING

Sibling includes sisters, brothers, half-sisters, half-brothers, adoptive sisters, adoptive brothers, step-sisters and step-brothers living in the same household.

1.37 SSI

SSI means Supplemental Security Income, or Title XVI of the Social Security Act.

1.38 STABILIZED

The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

1.39 STATE

State means the State of Rhode Island, acting by and through the Department of Human Services, Center for Child and Family Health, or its designees.

1.40 STOP-LOSS

Stop-loss provision means the mechanism by which the State will reimburse Contractor for the expenses of specific benefits exceeding limits referenced in this provision. Reimbursement to the plan will be at 90 percent of the current approved State Medicaid rate or 90 percent of the actual cost to the plan, whichever is less, except as noted. Stop-loss provisions will apply on a calendar year basis to individual RIte Care members.

Provisions will apply to:

- Long-term care in an intermediate or skilled facility in excess of 30 days
- Transplants; Contractor will be responsible for all costs up to the actual transplant of a bodily organ; costs associated with the transplant procedure will be reimbursed by the State to Contractor at the State-approved Medicaid rate or the actual cost, whichever is less.
- Early Intervention services in excess of $5,000 will be paid at the current State-approved Medicaid rate or the Health Plan rate, whichever is less.

1.41 URGENT MEDICAL CONDITION

Urgent Medical Condition means a medical (physical or mental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

1.42 UNINSURED

Uninsured means any individual who has no coverage for payment of health care costs either through

ENCLOSURE E

DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Financial Management Service
Division of Cost Allocation

26 Federal Plaza-Room 41-122
New York, New York 10278
PHONE: (212)-264-2069
FAX: (212)-264-5478

May 18, 2000

Mr. Ronald H. Gaskin
Assistant Director
Financial Management
State of Rhode Island
Department of Human Services
600 New London Avenue
Cranston, Rhode Island 02920

Dear Mr. Gaskin:

This is to advise you of the approval of the revision to the Department of Human Services Cost Allocation Plan, dated March 3, 2000. This revision to cost center (189), Title XIX Medicaid Administrative Costs for Local Education Agencies, was submitted in compliance with 45 CFR 95, Subpart E and is effective January 1, 2000.

This approval shall remain in effect until such time as the basis and methods for allocating costs stipulated in the plan becomes outdated due to organizational changes, changes in Federal law or regulations or there is a significant change in program composition that would effect the validity of approved cost allocation procedures.

The plan is approved and costs claimed in conformance with the plan are subject to the following conditions:

1. The approval is based on information provided by the State and is void if the information is later found to be materially incomplete or inaccurate.

2. The costs claimed for Federal financial participation must be allowable under the law, the cost principles contained in OMB Circular A-87 and program regulations.

3. The state agrees that only costs incurred after the execution date of interagency agreements are eligible for Federal claiming.

cc: P. Boulet
N. Brier

Nothing contained herein should be construed as approving activities not otherwise authorized by approved program plans, or Federal legislation or regulations.

The implementation of the cost allocation plan approved by this document may from time to time be reviewed by authorized Federal staff. The disclosure of inequities during such review may necessitate changes to the plan.

In addition, please acknowledge your concurrence with comment Number 3 by signing this letter in the space provided below and return it to me.

Sincerely,

Vincent J. Bamundo
Director, Division of
Cost Allocation

cc: Ronald Preston, HCFA

Enclosures

Concurrence:

Name

Title

5/23/00

Date

Mr. Vincent J. Bamunda, Director
Regional Administrative Support Center
Department of Health and Human Services
Division of Cost Allocation – Region II
Federal Building
26 federal Plaza
New York, NY 10278

Subject: Cost Allocation Plan for Cost Center 189

Dear Mr. Bamunda:

On March 3, 2000, the Rhode Island Department of Human Services (Department) submitted a revised Cost Allocation Plan for Cost center 189 to capture costs of Title XIX Medicaid Administrative Cost for Local Education Agencies (LEAs). On April 7, 2000, the Department submitted sample materials including a copy of the claiming manual describing the billing procedures to be used by the LEAs and a time study manual including instructions. On May 18, 2000, the subject revision to the Cost Allocation Plan was approved.

Because the Centers for Medicare & Medicaid Services (CMS) has issued new guidance[1] for claiming administrative costs under Cost Center 189, the Department has revised its claiming manual to reflect this guidance. The purpose of this correspondence is to formally transmit these revise materials to the Department of Health and Human Services (DHHS). Mr. Jack Briggs of the DHHS Region II Office reviewed these materials in draft form.

If you have any questions concerning this submission, please do not hesitate to contract me at (401) 462-6856.

Sincerely,

Ronald H. Gaskin
Assistant Director

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[1] Centers for Medicare & Medicaid Services. *Medicaid School-Based Administrative Claiming Guide*, May 2003.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

COST ALLOCATION PLAN

COST CENTER 189 - LOCAL EDUCATION AGENCIES, (L.E.A.) MEDICAID ADMINISTRATIVE COSTS – 50% F.F.P.

The Rhode Island Department of Human Services and the Local Education Agencies, (L.E.A.), have Medicaid provider agreements in place to provide health care services for children who are eligible for Medical Assistance. This cost center will capture the administrative costs associated with the administration and management of the Medicaid Program at local education authorities, which improves a student's access to and utilization of primary and preventative health care services. Salary and fringe benefit costs and associated related administrative costs are included in the total costs. A detail claiming and billing manual describes how the allowable costs will be calculated and allocated to Medicaid in accordance with O.M.B. Circular A-87.

Method A Direct Allocation.

ENCLOSURE F

RHODE ISLAND MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING GUIDE

Rhode Island Department of Human Services

September 2004

TABLE OF CONTENTS

I.

INTRODUCTION

Schools offer a unique opportunity to help enroll children in Medicaid, to assist children already enrolled, and to provide Medicaid-covered services to eligible children. Medicaid offers reimbursement for both the provision of covered medical services and for their associated administrative costs, such as outreach, enrollment assistance, and coordination activities. This *Medicaid School-Based Claiming Guide* (Guide) was developed by the Rhode Island Department of Human Services (DHS) to inform those involved with school-based Medicaid programs on the appropriate methods for claiming Federal and State reimbursement for the costs of Medicaid administrative activities performed in the schools. Expenditures for direct school-based health services that are covered by Medicaid and claimed as "Medical Assistance" are not discussed in this Guide.

Rhode Island Medicaid is a medical insurer that pays for medical, preventive, and /or evaluative services. School health personnel perform a variety of administrative activities that serve to assure the integrity and delivery of Medicaid services. The objective of Administrative Activity Claiming (ACC) is to identify the costs associated with allowable administrative activities that support the Rhode Island Medicaid Program and to assure that the administrative costs are appropriately claimed.

In developing this Guide, the following manuals/guides were reviewed and the appropriate requirements of those documents were incorporated into this Guide:

- *Medicaid School-Based Administrative Claiming Guide* released by the Centers for Medicare and Medicaid Services (CMS), May 2003.
- *Medicaid Direct Services Guidebook For Local Education Agencies,* Rhode Island Department of Human Services
- *Quarterly Administrative Activity Guide For Local School Districts,* Rhode Island Department Of Human Services
- *Time Study Manual For School-Based Administrative Activities,* The University Of Massachusetts Medical School

This Guide replaces DHS's Quarterly Administrative Activity Claiming Guide and the University of Massachusetts Medical School's Time Study Manual. The text in this Guide often reflects the same wording used in the other guides. If there are any questions about this Guide, please contact:

Name: Sharon Reniere

Address: Center for Child and Family Health
600 New London Ave.
Cranston, RI 02920

Telephone: (401) 462-2187

Fax: (401) 462-6353

E-mail: SReniere@dhs.ri.gov

II.

FEDERAL AND STATE REQUIREMENTS

This chapter lays out the Federal and State requirements for administrative claiming under school-based Medicaid services.

1. SCHOOL- BASED MEDICAID SERVICES

Federal matching funds are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligible individuals into Medicaid and that directly support the provision of medical services covered under the Medicaid State Plan. However, Medicaid third-party liability (TPL) rules and CMS' "free care" policy limit the ability of schools to bill Medicaid for some of the health services and associated administrative costs:

- Third-party liability (TPL) requirements preclude Medicaid from paying for services provided to Medicaid beneficiaries, if another third party (e.g., health insurer or other State or Federal programs) is legally liable and responsible for providing and paying for the services.

- The "free care" principle precludes Medicaid from paying for the cost of Medicaid-covered services and activities that are generally available to all students without charge and for which no other sources of reimbursement are pursued.

While schools are legally responsible to provide Individuals with Disabilities Education Act (IDEA)-related health services at no cost to eligible students, Medicaid reimbursement is available for those services because Section 1903(c) of IDEA requires Medicaid to be primary to the U.S. Department of Education for payment of the health-related services provided under IDEA.

2. INTERAGENCY AGREEMENTS

Any school district or local entity that receives payments for Medicaid administrative activities being performed in the school setting is acting as an agent of the State Medicaid agency. Such activities may be paid for under Medicaid **only** if they are necessary for the proper and efficient administration of the Medicaid State Plan. An interagency agreement that describes and defines the relationships between the Rhode Island Department of Human Services (DHS), the Rhode Island Department of Education (RIDE), and/or the school districts or local education agencies (LEAs) conducting the activities, must be in place to claim Federal matching funds. DHS is the only entity that may submit claims to CMS to receive Federal financial participation (FFP) for allowable Medicaid costs. This requirement necessitates that every other participating agency in Rhode Island be covered, either directly or indirectly, through an interagency agreement.

Interagency agreements may only exist between governmental (i.e., public) entities and cannot extend to private contractors or consultants. This does not mean, however, that private contractors or consultants cannot be used to provide applicable administrative services, but just that they are outside the scope of an interagency agreement.

Each interagency agreement must include: (1) mutual objectives, (2) defined responsibilities of all parities, (3) the activities conducted and the services provided by each party including the circumstances for provision, (4) cooperative and collaborative relationships, (5) specific administrative claiming time study activity codes approved by CMS, by reference or by inclusion, (6) specific methodology approved by CMS for the computation of claims either by reference or by inclusion, and (7) methods for reimbursement, exchange of reports and documentation, and liaison between the parties including the designation of State and local staff. The interagency agreement also should address the Medicaid administrative claiming process, identify the services DHS will provide to the local school entities including related reimbursement and funding mechanisms, and define oversight responsibilities and activities.

Prior approval of the interagency agreement(s) by CMS is not required, but any agreement is subject to CMS review.

3. TIME STUDY REQUIRED

LEA employees may perform administrative activities that directly support the Medicaid program. Some or all of the costs of these administrative activities may be reimbursable under Medicaid when an appropriate claiming mechanism is used.

A time study is the primary mechanism for identifying and categorizing Medicaid administrative activities performed by individual school and school district employees. The time study, including the activity codes used, must represent the actual duties and responsibilities of the employees. The time study is discussed in Chapter III of this Guide.

4. OPERATIONAL PRINCIPLES

Adherence to the following principles is required for claiming Medicaid administrative reimbursement:

- **Proper And Efficient Administration** – For the cost of any activity to be allowable and reimbursable under Medicaid, the activities must be "found necessary" by the Secretary of the U. S. Department of Health and Human Services (HHS) for the proper and efficient administration of the Medicaid State Plan. OMB Circular A-87 indicates: "Governmental units are responsible for the efficient and effective administration of federal awards." The principle of being necessary for the proper, efficient, and effective administration of the Medicaid State Plan must be applied in developing the time study codes. For example, outreach activities directed at explaining Medicaid are allowable, whereas outreach activities directed at explaining educational programs are not a Medicaid allowable administrative expense.

- **Capture 100 Percent of the Time** – States must develop a cost allocation methodology that is approved by HHS. The approved cost allocation methodology must include a method for conducting a time study to determine what services and activities LEA employees provide. The time study used may be: (1) a random moment sampling (RMS) study, (2) contemporaneous time sheets, or 3) other quantifiable measures of employee effort. The time study must incorporate a comprehensive list of activities performed by employees whose costs are claimed under Medicaid. The time study must reflect **all** of the time and activities (whether allowable or unallowable under Medicaid) performed by employees participating in the Medicaid administrative claiming program. The time study methodology must entail careful documentation of all work performed by the employees over a set period of time and is used to identify, measure, and allocate staff time devoted to Medicaid reimbursable activities. To ensure that all time study participants are appropriately reflected in the time study, the staff classifications and associated documentation (e.g., position descriptions) should be reviewed.

- **Parallel Coding Structure** – A Medicaid and a non-Medicaid code must exist for each activity. For example, LEA employees who provide referrals for both Medicaid and non-Medicaid programs will need to allocate their time appropriately between these programs.

- **Duplicate Payments** – States may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through alternative mechanisms or funding sources. Rhode Island must provide CMS with assurances that the methodology to allocate administrative costs and the claims for FFP preclude duplicate payments. Activities that would be considered as potential duplicative payments include: (1) integral parts or extensions of direct medical services such as patient follow-up, patient assessment, patient education, or patient counseling; (2) medical services paid for or that should be paid for by other programs or sources; (3) administrative costs already covered by another activity paid for by Medicaid; and (4) activities that are reimbursed by a RIte Care-participating Health Plan)[1] or the Rhode Island Medicaid program. It is important to distinguish between duplicate payments for the same activity and the inefficient use of resources that may result in the unnecessary performance of an activity more than once.

- **Coordination of Activities** – It is important in the design of the school-based program and in the subsequent claiming of administrative costs that the LEA not perform activities that are already being offered or should be offered by other entities or through other programs. This requires close coordination between the schools, DHS, RIDE, providers, community organizations, and other related entities. CMS has provided the following examples of activities that should be coordinated: (1) activities performed by Health Plans such as case management or care coordination; (2) payment rate-setting mechanisms and payments to providers; and (3) activities provided/conducted by other government programs (e.g., schools do not need to develop educational materials if the State Medicaid agency already developed materials as part of its Early Periodic Screening, Diagnosis and Treatment (EPSDT) program).

[1] For example: If a Health Plan's rates paid to school-based health clinics include referrals, then referrals to other providers by clinic staff would not be a Medicaid allowable cost.

- **Performing Direct vs. Administrative Activities** – The time study and activity codes must capture and clearly distinguish direct services from administrative activities. The activity codes must be designed to reflect all administrative activities conducted by the employees, even if Medicaid does not provide reimbursement for that activity. Activities that are considered integral to or an extension of other covered services should not be claimed as an administrative expense. For example, the practitioner should not bill separately for a referral as an administrative expense when the school is providing the direct service.

  - **Case Management as Administration** – Section 4302 of the *State Medicaid Manual* (SMM) identifies certain activities that may be properly claimed as administrative case management. An allowable administrative cost must be directly related to the Medicaid State Plan or waiver service and be necessary for the "proper and efficient administration of the state plan". Examples of administrative case management services include: (1) Medicaid eligibility determinations and re-determinations, (2) Medicaid intake processing, (3) Medicaid preadmission screening for inpatient care, (4) prior authorization for Medicaid services, (5) utilization review, and (6) Medicaid outreach.

  - **Case Management As A Service** – Case management as a service is designed to assist an individual eligible under the Medicaid State Plan in gaining access to needed medical, social, educational, and other services. Case management services are referred to as Targeted Case Management (TCM) services, when the services are not furnished in accordance with "State-wideness" or "comparability" requirements. As an "optional service" (i.e., under the State Medicaid Plan), this has enabled Rhode Island and other States to target TCM to specific classes of individuals (e.g., developmentally disabled individuals) or to individuals residing in specific areas. According to the Guide, particular attention must be paid to assure that case management, as a service, is not included as an administrative activity or cost. All TCM services must be reported under an activity code for direct medical service provision.

- **Allocable Share of Costs** – Since many school-based medical activities are provided both to Medicaid- and to non-Medicaid eligible students, the costs applicable to these activities must be allocated to both groups. OMB Circular A-87 states that "a cost is allocable to a particular cost object if the goods or services involved are chargeable or assignable to such cost objectives in accordance with the relative benefits received".

  Through the use of time study allocation methodologies, school personnel costs are attributed to Medicaid. The allocation methods and activity codes used must capture the following categories of cost:

  - **Unallowable** – The activity is unallowable as administration under the Medicaid program.

- **100% Medicaid Share** – The activity is solely attributable to the Medicaid program and is not subject to the application of the Medicaid share percentage.

- **Proportional Medicaid Share** – The activity is allowable as Medicaid administrative cost, but the allocable share of the costs must be determined by applying the percentage of the Medicaid eligible population to the total school-based population within the LEA.

- **Reallocated Activities** – Activities that must be reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

The *proportional Medicaid share* is sometimes referred to as the Medicaid eligibility rate, Medicaid percentage, allocable share, or discount rate. The *proportional Medicaid share* is the number of Medicaid students divided by the total number of students. The *proportional Medicaid share* is then applied to the total cost of a specific activity for which the school district is submitting claims for FFP. This process is necessary to ensure that only costs related to Medicaid eligible children are claimed. (It should be noted that not all activities are subject to the *proportional Medicaid share*; activities such as outreach and facilitating eligibility determination are not discounted).

The same time frames must be used for Medicaid-eligible and total students in the calculations. Allowable Medicaid costs are, then, the product of the *proportional Medicaid share* times the costs to be allocated.

DHS will provide each participating LEA with the number of Medicaid-eligible school-age children within the LEA on a quarterly basis. This will be the numerator for *proportional Medicaid share* for the applicable quarter. Each participating LEA will use the number of students enrolled during the applicable quarter as the denominator.

- **Enhanced FFP** – The enhanced FFP has been available for some school-based services. Two areas are addressed here in the Guide:

  - **Skilled Professional Medical Personnel (SPMP)** – The enhanced 75 percent match rate used to be available for SPMPs **is no longer available**. These professionals who must have completed a two-year program leading to an academic degree or certificate in a medically-related program and must have been engaged in an activity itself that required the use of the professional training and expertise. Although there are employees in LEAs who have the qualifications needed to be considered an SPSM, CMS has determined that their advanced skills and training are not necessary to perform the type of administrative activities that take place in a school setting. Therefore, effective January 1, 2003, FFP was no longer available at the enhanced 75 percent match rate for the costs associated with the activities performed by school-based SPMPs.

  - **Administration of Family Planning Services** – The enhanced 90 percent match rate is only for the "offering, arranging and furnishing" of family planning services. This

enhance rated is available for personnel who administer as well as directly provide certain family planning services and supplies. For LEAs that offer and/or arrange for family planning services **but do not actually furnish the services**, the costs for their administrative family planning activities[2] may be claimed at the 50 percent match rate.

- **Provider Participation** – An administrative activity performed in support of medical services not covered by Medicaid is **not** an allowable Medicaid administrative expense. For a medical service to be reimbursable, the provider must be a participating provider and bill Medicaid for the service. If a provider is not participating or chooses not to bill Medicaid for services, then the service as well as the associated administrative expense is **not** allowable. For medical expenses to be reimbursable under Medicaid, the following conditions must be met: (1) the services are furnished to a Medicaid-eligible individual; (2) the services are in the Medicaid State Plan or available and required through EPSDT; (3) the service is not provided free of charge to non-Medicaid eligible individuals; and (4) the provider is a participating provider with the Medicaid program, with a provider agreement and a Medicaid provider identification number, or is a provider of a RIte Care-participating Health Plan.

  An LEA does not have to be a participating Medicaid provider to claim FFP for referring students to a covered medical service in the community. As long as the provider who renders such services participates in Medicaid and the service itself is Medicaid reimbursable, then the referral may be claimed as an administrative expense.

  It is not always administratively efficient for the LEAs to verify for each referral whether a provider is participating in the Medicaid program. DHS and the LEA may develop a methodology to address this. The State/LEA may apply a proportional *provider participation rate* to represent the percentage of referrals made to Medicaid-participating providers. The *provider participation rate* can be used in lieu of having to determine on a case-by-case basis whether the referral is to a Medicaid-participating provider.

- **Individualized Education Program (IEP)** – The Catastrophic Coverage Act of 1988 permitted Medicaid payment for services provided to children under the Individuals with Disabilities Act (IDEA) through an Individualized Education Program (IEP). IDEA provisions require school staff to perform a number of education-related activities that can be characterized as child find activities to identify children with disabilities who need special education and related services, initial evaluation and reevaluation, and development of an IEP. These latter activities are **not** reimbursable as a Medicaid administrative expense. Outreach activities to identify children who are eligible for Medicaid **are** a reimbursable administrative expense.

- **Free Care** – The *free care* principle precludes Medicaid from paying for the costs of Medicaid-covered services and activities that are generally available to all students without charge, and for which no other sources of reimbursement are pursued. Thus,

[2] This type of activity would be reported under Code 9.b. (see Chapter IV of this Guide).

Medicaid cannot reimburse for routine school-based vision and hearing screenings or other preventive services provided free of charge to all students. Medicaid payments may be available for services or activities, if schools: (1) establish a fee for each available service; (2) collect third-party information from all those served; and (3) bill responsible parties.

Medicaid is the payer of last resort. Federal legislation requires Medicaid to be the primary payer for Medicaid services provided to eligible beneficiaries under IDEA, the Women's Infants and Children (WIC) program, or Title V programs, even if these programs do not bill non-Medicaid beneficiaries for services.

Medicaid only **will pay** for EPSDT services specified in the child's IEP, if the same service is provided free of charge to non Medicaid-eligible children. Medicaid reimbursement is **not** available for medical services or activities to make education accessible to children with disabilities.

5. CLAIMING ISSUES

The following are critical requirements for LEAs for claiming FFP:

- **Documentation** – The time study methodology, instructions, and cost allocation requirements issued by DHS to the LEAs stipulate the documentation the LEAs must maintain to support the claims submitted. The documentation for administrative activities must clearly demonstrate that the activities/services directly support the administration of the Medicaid program. The State is required to maintain and retain adequate source documentation to support the Medicaid payments for administrative claiming. The documentation must be sufficiently detailed to permit CMS to determine whether the activities were necessary for the proper and efficient administration of the Medicaid State Plan. The burden of proof and validation of time study results remains the responsibility of the State. While costs must be documented at least monthly, the time studies can occur on a quarterly basis or some other statistically valid time frame. Position descriptions will be considered by the State as supporting documentation for staff participating in time studies.

- **Offset of Revenues** – Certain revenues **must** offset allocation costs, which reduce the total amount of Federal reimbursement. The following are some of the revenue offset categories that must be applied in developing net costs: (1) all Federal funds; (2) all State expenditures that have been previously matched by the Federal Government; (3) insurance and other fees collected from non-governmental sources; (4) all applicable credits (e.g., those receipts or reduction of expenditure type transactions that offset or reduce expense items allocable to Federal award as direct or indirect costs); and (5) a program may not be reimbursed in excess of its actual costs (i.e., a profit cannot be made).

- **Timely Filing Requirements** – A claim for FFP must be filed within a two-year period that begins on the first day of the calendar quarter immediately following the quarter in

which the expenditure was made. Federal regulations (45 CFR 95.13(d) specify that the State Medicaid agency's expenditure for administration is made in the quarter the payment was actually made by the State Medicaid agency. In determining the two-year filing limit, the State agency must give consideration to the expenditure reporting cycle. The expenditure is not considered "filed" until it is received by CMS on the CMS-64 Expenditure Report, which is required to be filed 30 days after the end of the reporting quarter. This reduces the apparent amount of time in which the claim can be considered timely filed (because it is 30 days less than the permitted two years).

- **State Law Requirements** – To be allowable for FFP, costs must be authorized or not prohibited under State or local laws or regulations.

- **Contingency Fees** – Medicaid claims for the costs of administrative activities and direct medical services may not include fees for consultant services that are based on, or include, contingency arrangements. Thus, if payments to consultants by school are contingent upon payment by Medicaid, the consultant fee may **not** be used in determining the payments rate of school-based services and/or administration. While not Federally unlawful, paying consultants based on a percentage of billings is cautioned because it may lead to abusive billing practices such as "upcoding".

- **Third-Party Liability (TPL) and Payer of Last Resort** – TPL requirements preclude Medicaid from paying for Medicaid coverable services provided to Medicaid recipients if another payer is legally liable and responsible for providing and paying for the services. The Medicaid program is generally the payer of last resort. This principle is based in Medicaid statute under the TPL provisions and provisions relating to the consideration of an individual's income and resources in determining Medicaid eligibility. As previously indicated, IEP, Title V, and WIC are exceptions to this principle.

- **Transportation As Administration** – It is necessary to distinguish between the direct provision of transportation from those activities that support the provision of transportation services, such as arranging for transportation. The former may be claimed as a direct service and the latter may be claimed as an administrative cost.

- **Use of Billing Companies** – LEAs that contract with billing companies, or similar such entities, to facilitate the compilation of administrative claims on their behalf should be aware that the LEA is liable for any work performed by billing companies in compiling those claims. LEAs must assure that the any billing companies, or similar such entities, used to facilitate the compilation of administrative claims adhere to this Guide in any work performed on the LEA's behalf.

III.

TIME STUDY

A time study of school personnel will be the primary method used by the LEAs to determine the appropriate administrative costs that are attributable to the Medicaid program.

1. SAMPLE UNIVERSE

A basic step in the development of an approvable time study is the determination of the sample universe (i.e., which staff will participate in the time study). Medicaid administrative activities may be performed by LEA employees who also provide direct medical services (e.g., nurses physical therapists, and educational staff). If the costs of such staff are completely offset, then there is no purpose to include them in the sample universe. Only staff members for whom costs remain after applicable offsets should be included in the sample universe. It also may be appropriate to exclude medical staff who provide a specific service (e.g., screening conducted by an audiologist), are paid on a fixed fee basis, and do not perform any administrative activities.

A review of job descriptions may be helpful in determining who should be included in the time study. A list of job titles and staff who perform Medicaid administrative activities and are included in the sample universe must be maintained. The sampling universe must include all non- support staff whose costs are to be allocated.

It is likely that the following LEA employees will be included in the time study:

- **Skill Professional Medical Personnel** such as: Psychiatrics, Psychologists, Physicians, Speech Therapists, Occupational Therapists, Physical Therapists, Registered and Licensed Practical Nurses, Audiologists/Hearing Impaired/Vision Specialists, and Assistants

- **Other Medical And Service Personnel** such as Social Adjusters, Social Workers, and Case Managers

Direct support staff in special education, pupil support services, and nursing (such as directors, administrators, team leaders chairpersons clerical, and technical support staff) should not be included in the time study. Their costs will be allocated based on the results of the staff participating in the time study.

2. SAMPLING PLAN METHODOLOGY

Given the expected size of the sample universe of LEA personnel in Rhode Island, all LEA personnel in the sample universe are expected to participate in the time study for five consecutive days (these days are referred to as the "logging days") for each of the three quarters that school is in session. These quarters include: October–December, January-March, and April-June. A weighted average of the data from these three quarters will be used for the fourth quarter, when the schools are not in session (July-September).

The time study methodology for addressing the summer period must reflect the practices of the LEA. The results of the time studies performed during the regular school year may be applied to allocate the associated costs paid during the summer. In general, this is acceptable if the administrative activities are not actually performed during the summer break, but salaries are pro-rated over the year and paid during the summer break. However, if administrative activities are actually performed during the summer period, the application of the time study from the regular school year would not accurately reflect the costs associated with the summer activities. In this case, a time study also would have to be conducted during the summer period.

An LEA may request of DHS in writing that a random sample of the universe of LEA personnel be used, rather than the entire sample universe. Any such request from an LEA shall be accompanied by a description of the sampling plan methodology in sufficient detail to permit DHS to make a reasonable determination as to the adequacy of the methodology in meeting the requirements of this Guide. The random sample of the time study must achieve a 95 percent confidence level, with plus or minus 3 percent precision. It is recommended that the LEA over-sample to ensure an adequate number of responses. Non-responses should be considered non-Medicaid activities.

3. STAFF TRAINING

All staff in the sample universe must be adequately trained before the time study begins. Training must cover all aspects of the sampling process and conduct of the time study itself. Staff must be clear on how to complete the form, how to report activities under the appropriate time study code, what the differences are between health-related and other activities, and where to obtain technical assistance if questions arise during the sampling period. Professional staff must understand the distinctions between the performance of administrative activities and the direct provision of medical services. There must be a mechanism in place to assess the training and to revise the training as required.

4. TIME STUDY SHEET

The LEA personnel selected for the time study will complete a Time Study Sheet each day.

A Time Study Director will be selected by each LEA to coordinate the time study. The Director will distribute the Time Study Sheets daily to selected staff.

The LEA personnel selected for the time study must complete all sections of the Time Study Sheet daily, including the:

- **Staff Name** – This will be posted on the Time Study Sheet prior to distribution
- **LEA** – The name of the LEA/School District
- **Social Security Number** or **School District Employee Number**
- **Job Position Number** – This will be posted on the back of the Time Study Sheet
- **Date** – Completing the Time Study Sheet
- **Activities Performed During The Time Study Period** – Predefined activity codes will be used to indicate the activities that the personnel worked on during the day. These will be discussed in greater detail in the next chapter.
- **Signature** – Each Time Study Sheet must be signed by the school personnel

The LEA personnel participating in the time study must fill in the appropriate blanks of the Time Study Sheet with a #2 pencil. The entire bubble must be filled in. No "white-out" may be used on the Time Study Sheet, nor shall staples be used on the Time Study Sheet. The Time Study Sheet also should **not** be folded. If any school personnel are absent on the logging day due to personal leave, illness, vacation, or school cancellation, their Time Study Sheets still must be filled out nonetheless and the day charged to the General Administration activity code. LEA personnel are not required to tabulate the responses or to calculate the total time spent on a particular activity codes.

The time study participants should fill in only one bubble per 15-minute interval. The activity should represent the predominant activity that was performed during that 15-minute interval (i.e., the activity the participant spent the most amount of time on during that 15-minute interval.) One bubble must be filled in for each 15-minute increment during the workday. The activity codes are designed to account for all the activities performed during the day including lunch, breaks, etc. At the end of each **day or week** sampled, the school personnel will photocopy their Time Study Sheet and retain it for their own records. The original copy of the Time Study Sheet should be given to the Time Study Director at the end of each time study **day or week.**

5. TIME STUDY MONITORING

The Time Study Director will be responsible for assuring that:

- All LEA personnel selected for the Time Study handed in a Time Study Sheet each **day or week**
- All sections of the Time Study Sheet are completed

- All 15-minute increments/intervals are accounted for and marked
- All markings are legible, clear, and made with a #2 pencil, otherwise the Time Study Sheet must be redone
- A Time Study Sheet is completed for staff members who were selected for the Time Study, but were not in school that day
- The Time Study Sheet is signed and dated by the school personnel

The Time Study Director must get back with the LEA personnel on a **daily or weekly** basis when problems are found with the Time Study Sheets to correct them.

DHS will monitor the LEAs to assure compliance with the sampling methodology and to ensure that the time study is statistically valid (i.e., 95 percent confidence level or higher).

6. USE OF ELECTRONIC TIME STUDIES

LEAs may conduct their time studies electronically (e.g., on-line), as opposed to using a hard-copy Time Study Sheet. LEAs using electronic time study methods must specify procedures that ensure:

- Information is collected on a daily basis
- The time study is appropriately monitored
- Information submitted is protected in a secure environment
- Information submitted is attested to for accuracy by time study participants

7. TIME STUDY DOCUMENTATION

Documentation must be retained on the time study including: determining the sample universe, the actual sample selections (if any), sample results (if a sample is used), sample forms and work sheets, cost data for each LEA, and summary sheets showing how each LEA's claim was compiled.

When a portion of an employee's time is also billed as a medical service, then the administrative time study results should be validated by comparing the time coded to direct medical services to the actual number of hours billed directly.

The original Time Study Sheets and the position descriptions of the staff need to be retained by the LEA for seven years for audit purposes, to assure that the activities performed were for the proper and efficient administration of the Medicaid State Plan.

LEAs that perform time studies electronically must have a plan in place to back-up all information submitted electronically on a daily basis, and back-up files must also be maintained for seven years. If administrative claims are also compiled electronically, back-up files must be maintained for seven years.

IV.

ACTIVITY CODES

All LEAs will use a standard list of activities with uniform definitions in the Time Study. Exhibit III identifies the codes that will be used in the time study to determine Medicaid administrative costs for claiming FFP. The staff should include under each code the time spent on paper work, clerical activities, travel time, participating in training events, or providing translation services required to perform each activity.

EXHIBIT III

ACTIVITY CODES

CODE	ACTIVITY	ALLOCATION METHOD	ALLOWABILITY OF COSTS
1.a.	Non-Medicaid Outreach	Time Study	Unallowable
1.b.	Medicaid Outreach	Time Study	Allowable
2.a.	Facilitating Application for Non-Medicaid Programs	Time Study	Unallowable
2.b.	Facilitating Medicaid Eligibility Determination	Time Study	Allowable
3.	School-Related and Educational Activities	Time Study	Unallowable
4.	Direct Medical Services	Time Study	Unallowable
5.a.	Transportation for Non-Medicaid Services	Time Study	Unallowable
5.b.	Transportation for Medicaid Services	Time Study and Proportional Medicaid Share	Allowable
6.a.	Non-Medicaid Translation	Time Study	Unallowable
6.b.	Translation Related to Medicaid Services	Time Study and Proportional Medicaid Share	Allowable
7.a.	Program Planning, Policy Development, And Interagency Coordination Related To Non-Medical Services	Time Study	Unallowable
7.b.	Program Planning, Policy Development, And Interagency Coordination Related To Medical Services	Time Study and Proportional Medicaid Share	Allowable
8.a.	Non-Medical/Non-Medicaid Related Training	Time Study	Unallowable
8.b.	Medical/Medicaid Related Training	Time Study and Proportional Medicaid Share	Allowable
9.a	Referral, Coordination, And Monitoring Of Non-Medicaid Services	Time Study	Unallowable
9.b.	Referral, Coordination, And Monitoring Of Medicaid Services	Time Study and Proportional Medicaid Share	Allowable
10.	General Administration	Reallocated Based on Time Study	Allowable

The following describes the activity codes.

1. NON-MEDICAD OUTREACH (CODE 1.a.)

Non-Medicaid Outreach is an unallowable administrative cost, regardless of whether or not the population served includes Medicaid-eligible individuals. Staff should use this code when performing activities that inform individuals about their eligibility for non-Medicaid social, vocational, and educational programs, the benefits of these programs, and how to access them.

Examples of Non-Medicaid Outreach activities include:

- Informing families about wellness programs and how to access these programs
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices
- Conducting general health education programs or campaigns that address lifestyle changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.)
- Conducting outreach campaigns that encourage persons to access social, educational, legal, or other services not covered by Medicaid
- Assisting in early identification of children with special medical/dental/mental health needs through various child find activities
- Outreach activities that support programs that are 100 percent funded by State general revenue
- Distributing outreach materials such as brochures or handbooks for these programs
- Distributing outreach materials regarding the benefits and availability of these programs

2. MEDICAID OUTREACH (CODE 1.b.)

Medicaid Outreach refers to an activity that is 100 percent allowable as an administrative Medicaid cost and is reimbursable at 50 percent FFP. LEA staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program.

Examples of Medicaid Outreach activities include:

- Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment and screening), including services provided through the EPSDT program

- Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits.[3] LEA-developed outreach materials should have prior approval from DHS.

- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT

- Assisting DHS to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about resources available through the Medicaid program

- Providing information about EPSDT screening (e.g., dental and vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program

- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal and well-baby care programs and services

- Providing information regarding RIte Care and RIte Share, and RIte Care Health Plans to individuals and families and how to access them

- Encouraging families to access medical/dental/mental health services provided by the Medicaid program

3. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS (CODE 2.a.)

Facilitating Application for Non-Medicaid Programs is an unallowable Medicaid administrative cost, regardless of whether or not the population served includes Medicaid-eligible individuals. Staff should use this code when informing an individual or his/her family about and referring them to apply for such programs as Family Independence Program (FIP), Supplemental Security Income (SSI), Food Stamps, WIC, child care, legal aid, and other social and educational programs.

Examples of Facilitating Application for Non-Medicaid Programs include:

- Explaining the eligibility process for non-Medicaid programs, including IDEA

- Assisting the individual or family collect/gather information and documents for non-Medicaid program applications

- Assisting the individual or family in completing an application, including necessary translation activities

[3] This activity should not be used when Medicaid-related materials are already available to the schools (such as through DHS).

- Developing and verifying eligibility for the Free and Reduced Lunch Program
- Developing and verifying initial and continued eligibility for non-Medicaid programs
- Providing the necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination

4. FACILITATING MEDICAID ELIGIBILITY DETERMINATION (CODE 2.b.)

Facilitating Medicaid Eligibility Determination refers to an activity that is 100 percent allowable as an administrative Medicaid cost and is reimbursable at 50 percent FFP. LEA staff should use this code when assisting individuals in the Medicaid eligibility process.

Examples of Facilitating Medicaid Eligibility Determination include:

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants
- Assisting individuals and families to complete a Medicaid eligibility application
- Gathering information required for the Medicaid application and eligibility determination for an individual, including resource information and third-party liability (TPL) information, as a prelude to submitting a formal Medicaid application
- Providing the necessary forms and packaging all forms in preparation for the Medicaid eligibility determination
- Referring an individual or family to the local DHS office to make application for Medicaid benefits
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application
- Participating as a Medicaid eligibility outreach station, but this does not include determining eligibility

5. SCHOOL-RELATED EDUCATIONAL ACTIVITES (CODE 3)

School-Related Educational Activities are an unallowable Medicaid administrative cost, regardless of whether or not the population served includes Medicaid-eligible individuals. This code should be used for school-related activities, including social services, education services, teaching services, employment and job training, and other non-Medicaid related activities. This

code also should be used when conducting activities related to the development, coordination, and monitoring of a student's educational plan

Examples of School-Related Educational Activities, including related paperwork, clerical activities, and staff travel time required to perform them, include:

- Providing classroom instruction (including lesson planning)
- Testing and correcting papers
- Developing, coordinating, and monitoring the IEP for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the actual IEP meetings with parents[4]
- Compiling attendance reports
- Performing activities that are specific to instructional, curriculum, and student-focused areas
- Reviewing the education record of students who are new to the school district
- Providing general supervision of students (e.g., playground, lunchroom, etc.)
- Monitoring student achievement
- Providing individualized instruction (e.g., math concepts) to a special education student
- Conducting external relations related to school educational issues/matters
- Compiling report cards
- Carrying out discipline
- Performing clerical activities related to instructional or curriculum areas
- Activities related to educational aspects of meeting immunization requirements for school attendance
- Compiling, preparing, and reviewing reports on textbooks or attendance
- Enrolling new students or obtaining registration information

[4] If appropriate, this would also refer to the same activities performed in support of an Individualized Family Service Plan (IFSP).

- Conferring with students or parents about discipline, academic matters, or other school-related issues
- Evaluating curriculum and instructional services, policies, and procedures
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction, etc.)
- Translating an academic test for a student

6. DIRECT MEDICAL SERVICES (CODE 4)

This is an unallowable cost as a Medicaid administrative expense. The allowable costs associated with this code are reimbursed as a direct medical expense. Staff should use this code when providing care, treatment, and/or counseling services to individuals. Staff also should use this code when providing administrative activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, assessment, counseling, education, parent consultation, and billing).

Examples of Direct Medical Services, including related paperwork, clerical activities, and staff travel time required to perform them, include:

- Providing health/ mental health services contained in the IEP
- Medical/health assessment and evaluation as part of development of an IEP
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports
- Providing personal aide services
- Providing speech, occupational, physical, and other therapies
- Administering first aid or prescribed injections or medication to a student
- Providing direct clinical/treatment services
- Performing developmental assessments
- Providing counseling services to treat health, mental health, or substance abuse conditions
- Developing a treatment plan (medical plan of care) for a student, if provided as medical service

- Performing routine or mandated child health screens including, but not limited to vision, hearing, dental, scoliosis, and EPSDT screens
- Providing immunizations
- Providing Targeted Case Management
- Transportation
- Activities that are services, or components of services, listed in the Rhode Island Medicaid State Plan

7. TRANSPORTATION FOR NON-MEDICAID SERVICES (CODE 5.a.)

Transportation for Non-Medicaid Services is an unallowable cost, regardless of whether or not the population served includes Medicaid-eligible individuals. LEA staff should use this code when assisting an individual obtain or accompanying an individual on transportation trips for services not covered by Medicaid.

An example of Transportation for Non-Medicaid Services, including related paperwork, clerical activities, and staff travel time required to perform them, includes the scheduling and arranging for transportation to other services such as vocational, social, or educational activities.

8. TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID COVERED SERVICES (CODE 5.b)

This is an allowable administrative expense, but the allocable portion of the *proportional Medicaid share* must be applied. The *proportional Medicaid share* is reimbursed at 50 percent of FFP. Staff should use this code when assisting an individual to obtain transportation to Medicaid-covered services. This activity should not include the provision of the transportation since that is a direct cost.

An example of Transportation-Related Activities in Support of Medicaid Covered Services, including paperwork, clerical activities, and staff travel time required to perform them, includes the scheduling or arranging for transportation to Medicaid-covered services.

9. NON-MEDICAID TRANSLATION (Code 6.a.)

Non-Medicaid Translation is an unallowable Medicaid administrative cost, regardless of whether or not the population served includes Medicaid-eligible individuals. This code should be used for LEA staff who provide translation services for non-Medicaid activities.

Examples of Non-Medicaid Translation[5], including related paperwork, clerical activities, or staff travel time required to perform them, include:

- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, or vocational services

- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand State education or State-mandated health screenings (e.g., vision, hearing, or scoliosis) and general health education outreach campaigns intended for the student population

- Developing translation material that assist individuals to access and understand social, educational, and vocational services

10. TRANSLATION RELATED TO MEDICAID SERVICES (Code 6.b.)

Translation Related to Medicaid Services is an allowable administrative expense, but the allocable portion of the *proportional Medicaid share* must be applied. The *proportional Medicaid share* is reimbursed at 50 percent of FFP, if it is not included and paid for as part of a Medicaid-covered service. LEA staff who provide Medicaid translation services should use this code. However, translation must be provided either by separate units or separate staff performing solely translation function for the LEA and it must facilitate access Medicaid-covered services.[6]

Examples of Translation Related to Medicaid Services[7], including related paperwork, clerical activities, or staff travel time required to perform them, include:

- Arranging for translation services (oral and signing services) that assist the individual to access and understand necessary care or treatment covered by Medicaid

- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid

11. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES (CODE 7.a)

Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services are an unallowable administrative expense and are not reimbursable under the Medicaid program. LEA staff should use this code when performing activities associated with developing strategies to improve the coordination and delivery of non-medical services to school-age children. Non-medical services may include social services; educational services, vocational

[5] These activities may be reported under this code, or as an example within one or more other non-Medicaid activity codes (e.g., 1.a.).
[6] The LEA does not need to have a separate administrative claiming unit for translation.
[7] These activities may be reported under this code, or as an example within one or more other Medicaid activity codes (e.g., 1.b.).

services, and State education mandated child health screenings provided to the general school population. Employees whose position descriptions include program planning, policy development, and interagency coordination should use this code when conducting non-medical related activities.

Examples of Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services, including related paperwork, clerical activities, and staff travel required to perform them, include:

- Identifying gaps or duplication of non-medical services (e.g. social, vocational, educational, and State-mandated general health programs) to school-age children and developing strategies to improve the delivery and coordination of these services
- Developing strategies to assess or increase the capacity of non-medical school programs
- Monitoring the non-medical delivery systems in schools
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services
- Evaluating the need for non-medical services related to specific populations or geographic areas
- Analyzing non-medical data related to a specific program, population, or geographic area
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems
- Defining the relationship of each agency's non-medical services to one another
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and State-mandated screenings to the school populations
- Developing non-medical referral sources
- Coordinating with interagency committees to identify, promote, and develop non-medical services for the LEA

12. PROGRAM PLANNING, POLICY DEVELOPEMNT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES (CODE 7.b)

Program Planning, Policy Development, and Interagency Coordination Related to Medical Services are an allowable administrative expense, but the allocable portion of the *proportional Medicaid share* must be applied. The *proportional Medicaid share* is reimbursed at 50 percent of

FFP. LEA staff should use this code when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school-age children and when performing collaborative activities with other agencies or providers. Employees whose position descriptions and responsibilities include program, policy development, and interagency coordination should use this code.

Examples of Program Planning, Policy Development, and Interagency Coordination, including related paperwork, clerical activities, and staff travel time required to perform them, include:

- Identifying gaps or duplication of medical/dental/mental services to school-age children and developing strategies to improve the delivery and coordination of these services
- Developing strategies to assess or increase the capacity of school medical/dental/mental programs
- Monitoring the medical/dental/mental health delivery systems in schools
- Developing procedures for tracking families' request for assistance with medical/dental/mental health services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services)
- Evaluating the need for medical/dental/mental health services in relation to a specific populations or geographic areas
- Analyzing Medicaid data related to a specific program, population, or geographic area
- Working with other agencies and/or providers that provide medical/dental/mental health services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible, and to increase provider participation and improve provider relations
- Working with other agencies and/or providers to improve the collaboration around the early identification of medical/dental/mental health problems
- Defining strategies to assess or increase the cost-effectiveness of school medical/dental/mental health programs
- Defining the relationship of each agency's Medicaid services to one another
- Working with Medicaid resources (e.g., DHS or RIte Care Health Plans) to make good faith efforts to locate and develop EPSDT health services referral relationships
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school population

- Working with DHS to identify, recruit, and promote the enrollment of potential Medicaid providers

- Developing medical referral sources such as directories of Medicaid providers and Health Plans that provide services to targeted population groups (e.g. EPSDT)

- Coordinating with interagency committees to identify, promote, and develop EPSDT services in the LEA

13. NON-MEDICAL/NON-MEDICAID RELATED TRAINING (Code 8.a.)

Non-Medical/Non-Medicaid is an unallowable administrative expense and is not reimbursable under the Medicaid program. LEA staff should use this code when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the programs other than the Medicaid program. For example, training may include how to assist families to access the services of education programs and how to more effectively refer students for these services.

Examples of Non-Medical/Non-Medicaid Related training, including related paperwork, clerical activities, and staff travel required to perform them, include:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid

- Participating in or coordinating training that enhances IDEA child find programs

14. MEDICAL/MEDICIAD RELATED TRAINING (Code 8.b)

Medical/Medicaid Related Training is an allowable administrative expense, but the allocable portion of the *proportional Medicaid share* must be applied. The *proportional Medicaid share* is reimbursed at 50 percent of FFP. LEA staff should use this code when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer students for services.

Examples of Medical/Medicaid Related Training, including related paperwork, clerical activities, and staff travel required to perform them, include:

- Participating in or coordinating training that improves the delivery of medical/Medicaid related services

- Participating in or coordinating training that enhances early identification, intervention, screening, and referral of students with special health needs to such services (e.g., Medicaid EPSDT services)[8]

[8] This is distinguished from IDEA child find services.

- Participating in training on administrative requirements related to medical/Medicaid services

15. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES (CODE 9.a)

Referral, Coordination, and Monitoring of Non-Medicaid Services[9] is an unallowable administrative expense and is not reimbursed under the Medicaid program. School staff should use this code when they are making referrals for, coordinating, and/or monitoring the delivery of non-medical services of students, such as educational services.

Examples of Referral, Coordination and Monitoring of Non-Medicaid Services, including related paperwork, clerical activities, and staff travel required to perform them, include:

- Making referrals for and coordinating access to social and educational services (e.g., child care, employment, job training, housing, etc.)
- Making referrals for, coordinating, and/or monitoring the delivery of child health screens (e.g. vision, hearing, scoliosis, etc.) required the jointly promulgated *Rules and Regulations for School Health Programs* (R16-21-SCHO)
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations
- Gathering any information that may be required for these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid
- Monitoring and evaluating the non-medical components of the IEP, as appropriate

16. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES (CODE 9.b)

Referral, Coordination, and Monitoring of Medicaid Services is an allowable administrative expense, but the allocable portion of the *proportional Medicaid share* must be applied. The *proportional Medicaid share* is reimbursed at 50 percent of FFP. Staff should use this code when making referrals for, coordinating, and/or monitoring activities related to services in an IEP. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a direct service (e.g., patient follow-up, patient assessment, patient counseling, patient education, and patient consultation

[9] It should be noted that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management, or may also be referred to as Referral, Coordination, and Monitoring of Non-Medical Services. Case management may also be provided as an integral part of the service and would be included in the service cost.

activities) should be reported as Direct Medical Services (Code 4). Activities related to the development of an IEP should be reported as Code 3, School-Related Educational Activities.

Examples of Referral, Coordination, and Monitoring of Medicaid Services[10], including related paperwork, clerical activities, and staff travel necessary to perform them, include:

- Identifying and referring adolescents who may be in need of Medicaid family planning
- Making referrals for and/or coordinating medical or physical examinations and necessary medical, dental, and mental health evaluations
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunizations, but do not include State-mandated health services
- Referring students for necessary medical, mental health, or substance abuse services covered by Medicaid
- Arranging for any Medicaid-covered medical/dental/mental health diagnostic or treatment services that may be required as a result of a specifically identified medical/dental/mental health condition
- Gathering any information that may be required in advance of medical/dental/mental health referrals
- Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid
- Providing follow-up contact to ensure a child has received the prescribed medical/dental mental health service covered by Medicaid
- Coordinating the delivery of community based medical/dental/mental health services for a child with special health care needs
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care

[10] *Ibid.*

- Providing information to other staff on the child's related medical/dental/mental health services and plans
- Monitoring and evaluating the Medicaid service components of the IEP, as appropriate
- Coordinating the medical/dental/mental health service provision with managed care organizations (MCOs), as appropriate

17. GENERAL ADMINISTRATION (CODE 10)

General Administration is an allowable administrative cost determined by reallocating the costs across the other activities based on the results of the time study. Time study participants should use this code when performing activities that are not directly assignable to the other program activities noted above. Lunch, breaks, leave, and other paid time when not at work may be accounted for under this code. Certain functions such as payroll, developing budgets, and executive direction are only allowable through the application of an indirect cost rate and should not be accounted for under this code.

Examples of General Administration activities, including related paperwork, clerical activities, and staff travel required to perform them, include:

- Taking lunch, breaks, leave, or other paid time not worked
- Establishing goals and objectives of health-related programs for the school's annual or multi-year plan
- Reviewing school or district procedures and rules
- Attending school staff meetings, training, or board meetings
- Performing administrative or clerical activities related to general building or district functions or operations
- Providing general supervision of staff, including supervision of students teachers or classroom volunteers, and evaluation of employee performance
- Reviewing technical literature and research articles
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes

V.

MEDICAID ADMINISTRATIVE COST CALCULATIONS

This chapter describes how to determine the allowable administrative cost that is attributable to the Medicaid program.

1. TIME STUDY RESULTS

Initially, the percentage of time spent on each activity in relation to the total time available will be calculated. Exhibit IV is a Time Study Summarization Form, which may be used to calculate the percentage of time spent on each activity. In calculating the percentages, LEA-specific work requirements should be taken into account (e.g., staff work 1,785 minutes per week, 29.75 hours per week, 357 minutes per day, and 5.95 hours per day).

The amount of time spent of General Administration (Code 10), denoted by the ** in Exhibit IV, must be reallocated across the other codes based on the time spent on the other activities. The reallocated percentage (the far-right column) will be used for calculating the administrative claim.

EXHIBIT IV

TIME STUDY SUMMARIZATION FORM

TIME PERIOD: _____

ACTIVITY CODE	TOTAL NUMBER OF MINUTES PER ACTIVITY CODE	TOTAL NUMBER OF STAFF	TOTAL NUMBER OF MINUTES WORKED PER WEEK	PERCENTAGE OF TIME SPENT PER ACTIVITY CODE	REALLOCATED PERCENTAGE OF TIME SPENT PER ACTIVITY CODE
1.a.					
1.b.					
2.a.					
2.b.					
3.					
4.					
5.a.					
5.b.					
6.a.					
6.b.					
7.a.					
7.b.					
8.a.					
8.b.					
9.a.					
9.b.					
10			**		
TOTAL	*		*	100 %	

* These totals should equal

2. STAFF COSTS

The data on the actual costs of the staff participating in the time study should be gathered. These actual staff costs include:

- Salaries
- Fringe Benefits And Related Payments (e.g., health insurance, life insurance, pension, 401(k) contributions, worker's compensation insurance, unemployment insurance, Medicare, and FICA, if applicable)
- Other Direct Staff Costs

The LEA should determine the costs for that quarter for every staff member participating in the time study as well as for all the direct support staff who did not participate in the time study, whose costs will be allocated based on the results of the time study. It may be easier for the LEA to determine the staff costs on an annual basis and, then, allocate a one-fourth of the costs to the reported quarter, assuming that the costs do not vary among quarters.

Any lump sum staff cost payments (e.g., retirement benefits) should be included in the quarter in which such costs are incurred.

Exhibit V provides a sample Staff Cost Report.

3. PRIVATE SPECIAL EDUCATION SCHOOLS

For Private Special Education Schools, the health-related portion of the quarterly tuition is captured by taking the quarterly day school tuition payment plus the quarterly residential school; tuition payments are, then, reduced by a State-wide room and board discount factor multiplied by the State-wide health-related percentage per job position group. The allowable health-related portion of tuition costs is allocated to the appropriate job position grouping, which is subject to the time study results.

EXHIBIT V

STAFF COST REPORT

(A) TIME STUDY STAFF: ______________________________

(B) DIRECT SUPPORT STAFF: __________________________

CALCULATION/REPORTING PERIOD: _________________

STAFF NAME	JOB CODE	(1) SALARY	(2) FRINGE BENEFIT COSTS	(3) OTHER DIRECT COSTS	(4) TOTAL COSTS
		$	$	$	$
Total		$	$	$	$

4. RESTRICTED FEDERAL FUNDS

Restricted Federal funding should be deducted from the actual expenses. Only local, State, and Federal sources should be included in the claim calculations,

5. CAPITAL COSTS

The following describes how to treat the capital costs for claiming reimbursement for administrative expenses associated with Medicaid:

- **BUILDING AND FIXED ASSETS** – Identify the current annual value of the LEA's building and fixed assets. Then, identify the square footage in the LEA for the space occupied by the staff in the job positions categories included in the time study. Identify the school's total square footage. In the event that space is used for multiple purposes, only include the allocated percentage of square footage directly related to the actual time usage by the staff participating in the time study. Multiple the total building and fixed valuation by the percentage of the square feet occupied by the staff participating in the time study. Multiply this amount by 2 percent.

- **MAJOR MOVABLE EQUIPMENT** – Identify the current annual value of major movable equipment used by the staff in the job positions categories included in the time study. Multiple this amount by 6.67 percent.

  Building, fixed, and major movable valuations shall be based on the acquisition cost of the assets involved. A reasonable estimate of the original acquisition cost may be used when actual cost records have not been maintained. The asset valuation shall exclude: (1) the land cost, (2) any portion of the school building or equipment cost that is used to satisfy a Federal matching requirement, and (3) the annual use allowance calculation for buildings and fixed equipment computed at an annual rate not exceeding 2 percent of the acquisition cost. The annual allowance calculation for major movable equipment will be computed at an annual rate not to exceed 6.67 percent of the acquisition cost.

  Assets included in this calculation must be supported by adequate property records. Municipalities must manage equipment in accordance with State laws and procedures. Physical inventories must be taken at least once every two years (a statistical sampling approach is acceptable) to ensure that assets exist and are in use.

- **INTEREST EXPENSES** – Identify the LEA's current interest expense associated with school building acquisition, construction, remodeling, and equipment. Allowable interest must meet the following criteria: (1) the financing is provided by a bona fide third party external to the municipality or LEA, (2) the assets are used in support of the Medicaid Program, and (3) earnings on debt service reserve funds are used to offset the current period's internal costs.

The calculated amounts for building/fixed assets, major movable equipment, and interest expenses will be added to determine the annual gross claim amount for capital. The annual amount will, then, be divided by 4 to calculate the quarterly amount.

Exhibit VI provides a sample Capital Calculation Form.

EXHIBIT VI

CAPITAL CALCULATION FORM

EXPENSES	(1) TOTAL COST	(2) SQ. FT. %	(3) APPLICABLE COST	(4) FACTOR %	(5) CLAIMABLE COST
(a) Building/Fixed Assets	$	%	$	2%	$
(b) Major Movable Assets for Job Position Groups	$	%	$	6.67%	$
(c) Interest Expenses	$	%	$	%	$
(d) Annual Capital Expenses (a + b + c)	$		$		$
(e) Percentage of Medicaid Personnel Costs to Total LEA Personnel Costs		%			
(f) Health-Related Portion of Capital Expenses (d x e)					$
(g) Quarterly Health-Related Capital Expenses (f / 4)					$

The LEA must identify the most recent unrestricted indirect cost rate for Federal grants by contacting RIDE (Rhode Island Department of Education).

6. CALCULATING THE CLAIM

Exhibit VII provides a sample Claim Calculation Form to determine the allowable administrative Medicaid costs. The following are the major steps.

- **Step 1** – Take the far-right column (Reallocated Percentage of Time Spent per Activity Code) from the Time Study Summarization Form (Exhibit IV) and copy it to Column 1 on the Claim Calculation Form (Exhibit VII)

- **Step 2** – Multiple the total quarterly staff cost for staff participating in the time study (Column 4 total in Exhibit IV-A) by the reallocated time percentages in Column 1 and put the results in Column 2.

- **Step 3** – Multiple the total quarterly direct support staff cost (Column 4 in Exhibit V-B) by the reallocated time percentage in Column 1 and put the results in Column 3.

- **Step 4** – Multiply the Quarterly Health-Related Capital Expenses (Column 5 in Exhibit VI) and, then, multiple the result by the reallocated percent of time in Column 1 and put the results in Column 4.

- **Step 5** – Add Columns 2, 3, and 4 to obtain the Total Cost Pool for each activity and put the results in Column 5.

- **Step 6** – Apply the *proportional Medicaid share* percentage (the ratio of the Medicaid population to the total school population) to Activity Codes 5.b., 6.b., 7.b, 8.b., and 9.b. to obtain a Proportional Medicaid Share Cost and put this in Column 6. The Total Cost Pool (Column 5) and Gross Claim Amount (Column 6 should the same, **except** for Activity Code 7.b. Program Planning, Policy Development and Interagency Coordination Related to Medical Services.

EXHIBIT VII

CLAIM CALCULATION FORM

ACTIVITIES	(1) REALLOCATED % OF TIME	(2) TIME STUDY STAFF COST	(3) DIRECT SUPPORT STAFF COST	(4) CAPITAL COST	(5) TOTAL COST POOL	(6) GROSS CLAIM AMOUNT
1.a.	%	$	$	$	$	$
1.b.						
2.a.						
2.b.						
3.						
4.						
5.a.						
5.b.						
6.a.						
6.b.						
7.a.						
7.b.						
8.a.						
8.a.						
9.a.						
9.b.						
10.						
TOTAL		$	$	$	$	$

Exhibit VIII provides a sample Claims Submission Summary. The following steps must be taken:

- **Step 1** – Add all the allowable gross claim amounts for activities reimbursed at 50 percent FFP (i.e., Code 1.b.: Medicaid Outreach; Code 2.b.: Facilitating Medicaid Eligibility Determination; Code 5.b.: Transportation Related Activities in Support of Medicaid Covered Services; Code 6.b.: Translation Related to Medicaid Services; Code 7.b.: the Medicaid-proportioned Program Planning, Policy Development and Interagency Coordination Related to Medical Services; Code 8.b.: Medical/Medicaid Related Training; and Code 9.b.: Referral, Coordination and Monitoring of Medicaid Services) and enter this amount on Row A. Multiply the total cost of these activities by 50 percent to obtain a Gross Claim Cost in Column 3.

- **Step 2** – Re-enter the amount on Line A as the Allowable Direct Costs on Row B.

- **Step 3** – Multiple the Allowable Direct Costs by the State's approved indirect cost rate (Row C) to determine the Allowable Indirect Costs (Row D).

- **Step 4** – Add Allowable Direct Costs (Row B) to the Allowable Indirect Costs (Row D) to determine the Allowable Medicaid Administrative Costs (Row E) for the quarter.

EXHIBIT VII

CLAIM SUBMISSION SUMMARY

	(1) GROSS CLAIM AMOUNT	(2) FFP	(3) GROSS CLAIM COST
(A) Activities 1.b.,2.b.,5.b.,6.b,7.b.,8.b.,9.b	$	50%	$
(B) Allowable Direct Costs (A)	$		$
(C) Allowable Indirect Cost Rate	%		
(D) Allowable Indirect Costs (B x C)			$
(E) Allowable Medicaid Administrative Costs (C + E)			$

7. SUBMITTING THE CLAIM

Quarterly claims should be submitted to the Department of Human Services within 15 days of the end of each quarter. The following items should be included when submitting the LEA's quarterly claim:

- Quarterly Claims Submission Summary
- Claim calculation detail
- Capital calculation detail
- Fringe benefit calculation
- Detailed expenditure report
- State-wide summary for Special Education tuition

Quarterly claims should be submitted to:

Name: Mr. Timothy McCormack
Assistant Director

Address: Department of Human Services
600 New London Avenue
Cranston, RI 02920

Telephone: (401) 462-6858